UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

STEPHEN McCOLLUM, and SANDRA McCOLLUM, individually, and STEPHANIE KINGREY, individually and as independent administrator of the Estate of LARRY GENE McCOLLUM, PLAINTIFFS	§	
v.	§	CIVIL ACTION NO. 4:14-cv-3253 JURY DEMAND
BRAD LIVINGSTON, JEFF PRINGLE, RICHARD CLARK, KAREN TATE, SANDREA SANDERS, ROBERT EASON, the UNIVERSITY OF TEXAS MEDICAL BRANCH and the TEXAS DEPARTMENT OF CRIMINAL JUSTICE. DEFENDANTS	§	

Plaintiffs' Consolidated Summary Judgment Response Appendix

EXHIBIT 59

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

STEPHEN McCOLLUM, STEPHANIE KINGREY, and SANDRA McCOLLUM, individually and as heirs at law to the Estate of LARRY GENE McCOLLUM. PLAINTIFFS	§	
v.	§	CIVIL ACTION NO. 3:12-CV-2037-L
BRAD LIVINGSTON, JEFF PRINGLE, and TEXAS DEPARTMENT OF CRIMINAL JUSTICE. DEFENDANTS	§	

AFFIDAVIT FOR AUTHENTICATION OF MEDICAL RECORDS

RECORDS PERTAINING TO: **Larry McCollum; DOB: 04/04/1953**

RECORDS REQUESTED: ANY & ALL MEDICAL RECORDS, including but not limited to, history & physical, diagnoses, prognoses, any and all radiological reports, consultations, operative reports, office records, clinic records, therapy records, E.R. records, progress notes, narratives, discharge summary, notes (including handwritten notes by doctors or other staff member), tests, test results, rehabilitation records, memoranda and correspondence pertaining to:

Before me, the undersigned authority, personally appeared **ELLA ROMANO**, who being by me duly sworn, deposed as follows:

"My name is **ELLA ROMANO**. I am over 18 years of age, of sound mind, capable of making this affidavit, and personally acquainted with the facts herein stated.

I am the custodian of records, and as such, I am the custodian of the records of Hutchins Fire Department - EMS.

The records attached to this affidavit, consisting of **5** pages **0** films were made and kept by Hutchins Fire Department - EMS in the regular course of business. It was in the regular course of that business, for an employee, or representative, with knowledge of the acts, events, conditions, opinions, or diagnoses recorded to make the record or to transmit information thereof to be included in such record; and the record was made at or near the time or reasonably soon thereafter. The records attached hereto are exact duplicates of the originals."

AFFIANT (Custodian of Records)

Sworn to and subscribed before me this **18** day of **JUNE**, 2013.

My commission expires: 5/15/15

Notary Public

NOTARY PUBLIC-STATE OF FLORIDA
Marisol Bridgemohan
Commission # EE094079
Expires: MAY 15, 2015
BONDED THRU ATLANTIC BONDING CO., INC

City of Hutchins
321 North Main St.
HUTCHINS, TX 75141
972-225-3311

AMBULANCE RECORD

6778032 (wpharvill)

Trip Information

Incident#:	Date	Station	Responding Unit
11-573	07-22-2011	Station 1	Medic 701

Branch

Dispatched As	Found To Be	Patient Disposition
Convulsions/Seizure	Convulsions/Seizure	Transport and treatment

Department Directive

Dispatched	Enroute	Amb On Loc	Pt Contact	Depart Loc	Arrive Hosp	In Service
03:05	03:09	03:12	03:23	03:36	03:54	04:21

Pickup	Destination
Hutchins State Jail 1101 E. Langdon HUTCHINS, TX 75141	Parkland Hospital East ER 5201 Harry Hines DALLAS, TX 75235

Response To Scene		Response From Scene	Lights & Sirens
Map Page		Miles Transported	15.00
County	DALLAS	County	DALLAS
		Number of Patients Transported	1

Patient Information

Patient Name	TDCJ #	Gender	Ethnicity
McCollum, Larry	1721640	Male	

Patient Residence	Date of Birth	DL
1101 E. Langdon HUTCHINS TX 75141	01-01-1900 (111 YO)	TEXAS

Phone (H)	Phone (W)	Height	Weight	SSN
		6' 0"	400.00 lbs	

Patient Information

Allergies	Unknown
Medications	Unknown
History	Unknown
Chief Complaint	Convulsions/Seizure

Cardiac

Cardiac Arrest	Etiology	Resuscitation Attempt
No		

Initial Patient Assessment

An ALS Assessment was Performed and Warranted

LOC	BP	SpO2	ETCO2		
AAOx1	136/108	80% RA			
Breath Sounds Upper Left: Clear Right: Clear	Breath Sounds Lower Left: Clear Right: Clear		Resp Rate 14	Pulses Left: Radial Right: Radial	
Pulse Rate 127	Pupils Left: PERRL Right: PERRL	Capillary Refill Instant			
Skin Color Pale	Skin Moisture Wet	Skin Temp Hot	Skin Appearance		
Blood Glucose 200 mg/dL					

Glasgow Coma Score

GCS Total	Eye Opening	Verbal Response	Motor Response	RTS
8				10

Electronically Signed

Harvill, William P (EMT-P) Crew #1 Pressler, Terry D (EMT-P) Crew #2

City of Hutchins
321 North Main St.
HUTCHINS, TX 75141
972-225-3311

AMBULANCE RECORD

6778032 (wpharvill)

Sequence Chart

Date	Time	Event	By	Description
07-22-2011	03:05	Dispatched		
07-22-2011	03:09	Enroute		
07-22-2011	03:12	On Location		
07-22-2011	03:23	Patient Contact		
07-22-2011	03:25	Other Event		Moved patient out of cell
07-22-2011	03:30	Vitals	TDP	BP 136/108, Pulse 127, Respirations 12, SPO2 80% on RA taken by Pressler, Terry D.
07-22-2011	03:31	Oxygen	WPH	15.00 LPM per on Scene medical direction. The Patient's condition was .
07-22-2011	03:33	Vitals	WPH	BP 134/106, Pulse 124, Respirations 12, SPO2 96% on O2 taken by Harvill, William P.
07-22-2011	03:33	Blood Sugar Level	TDP	Blood Sugar monitoring was performed by Pressler, Terry D and found to be 200 mg/dL.
07-22-2011	03:33	Other Event	WPH	Temp 106 Degree F
07-22-2011	03:34	EKG	WPH	Sinus Tachycardia.
07-22-2011	03:35	IV/IO	TDP	A 18g was attempted by Pressler, Terry D without success. Blood was not drawn.
07-22-2011	03:36	Departed Location		
07-22-2011	03:37	Cold Pack	WPH	Neck and under arms
07-22-2011	03:40	Report Called	WPH	Report Called to RN via Phone.
07-22-2011	03:54	Arrived Destination		
07-22-2011	03:54	Assessment	WPH	Patient never changed condition
07-22-2011	03:54	Vitals	WPH	BP 134/106, Pulse 122, Respirations 12, SPO2 97% on O2 taken by Harvill, William P.
07-22-2011	04:21	In Service		

Patient Assessment at Destination

LOC AAOx1	**BP** 132/106	**SpO2** 97% O2	**ETCO2**		
Breath Sounds Upper Left: Clear Right: Clear	**Breath Sounds Lower** Left: Clear Right: Clear		**Resp Rate** 12	**Pulses** Left: Radial Right: Radial	
Pulse Rate 122	**Pupils** Left: Fixed,Dilated Right: Fixed,Dilated	**Capillary Refill** 1-2 seconds			
Skin Color Pale	**Skin Moisture** Moist	**Skin Temp** Hot	**Skin Appearance**		
Blood Glucose 200 mg/dL					

Electronically Signed

Harvill, William P (EMT-P) Crew #1
Pressler, Terry D (EMT-P) Crew #2

Patient Name: McCollum, Larry | Incident Date: 07-22-2011

City of Hutchins
321 North Main St.
HUTCHINS, TX 75141
972-225-3311

AMBULANCE RECORD

Narrative

Subjective:
Medic 701 dispatched to convulsions/seizure call and found male patient complaining of Convulsions/Seizure. Bystander states loss of consciousness. Bystander witnessed seizure activity.

Objective:
Patient offered no communication. Upon EMS arrival, patient was lying supine. Patient had an irregular gait. Patient was unconscious.

Systemic Information - Assessment
Skin: Hot Wet
Head / Neck: Temp 106 degree F
Chest: Clear
Abdomen: Soft
Extremities: FULL ROM
Head/Face: Normal
Neck: Normal
Heart: Normal
Abdomen Left Upper: Normal
Abdomen Left Lower: Normal
Abdomen Right Upper: Normal
Abdomen Right Lower: Normal
GU Assessment: Normal
Back Cervical: Normal
Back Thoracic: Normal
Back Lumbar/Sacral: Normal
Extremities-Right Upper: Normal
Extremities-Right Lower: Normal
Extremities-Left Upper: Normal
Extremities-Left Lower: Normal

General: AAOx1, Initial BP 136/108, Pulse 127, Respirations 14 and snoring
Monitors: SPO2 80% RA

Assessment:

Plan:
Male patient found complaining of Convulsions/Seizure postictal. Initial assessment as indicated. Pulse rate was 127. Respirations were 14 and snoring. Initial blood pressure was 136/108. Initial SpO2 was 80% RA. Patient contact made at time indicated above. Oxygen was applied at 15 LPM via Re-breather mask. The patient's condition Improved. Blood Sugar monitoring was performed by Pressler, Terry D (EMT-P) and found to be 200 mg/dL.An EKG was performed by Harvill, William P (EMT-P). The patient's rhythm was Sinus Tachycardia in lead II.A 18g Ante cubital-Left IV was attempted by Pressler, Terry D (EMT-P) without success. Cold pack applied to Neck and under arms. A patient report was called in to the receiving facility. An additional assessment was performed, as indicated. Patient was transported lights & sirens to Parkland Hospital East ER and released to staff. Upon transfer of patient care to ED staff, the patient's symptoms remained unchanged.

Electronically Signed

Harvill, William P (EMT-P) Crew #1
Pressler, Terry D (EMT-P) Crew #2

City of Hutchins
321 North Main St.
HUTCHINS, TX 75141
972-225-3311

AMBULANCE RECORD

6778032 (wpharvill)

Image 1/1

Assignment of Benefits/HIPAA Acknowledgement Form

I understand that I am financially responsible for the services provided to me by City of Hutchins I request that payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf to City of Hutchins for any services provided to me by City of Hutchins now or in the future. I agree to immediately remit to City of Hutchins any payments that I receive directly from any source whatsoever for the services provided to me now or in the future. I assign all rights and/or benefits to such payments to City of Hutchins for compensation of services provided to me now or in the future.

I authorize and direct any holder of medical information or documentation about me to release such information to the Centers for Medicare and Medicaid Services and its carriers and agents, and/or City of Hutchins and its billing agents, and/or any other payers or insurers, as may be necessary to determine these benefits or other benefits payable for services provided to me by.

✓ Yes, I acknowledge that I have received a copy of City of Hutchins Notice of Privacy Practices.

A copy of this form is as valid as the original.

Patient Release of Responsibility

____(Patient's initials) I have been informed of the reason the emergency medical personnel feel that I should go to the emergency center for further evaluation.

____(Patient's initials) I have been informed of the evaluation and/or treatment that may/will occur at the emergency center.

____(Patient's initials) I have been informed of the consequences and/or complications that may result due to my refusal to go to the emergency center for further evaluation.

Initial one of the following:

____I, the undersigned, have been advised that emergency medical treatment on my/the patient's behalf is necessary, and that refusal of recommended treatment and transport to an emergency center may result in death, or imperil my/the patient's health by increasing the opportunity for morbidity. Nevertheless, and understanding all of the above, I refuse to accept further emergency medical treatment and/or transportation to an emergency center, assume all risks and consequences resulting from my decision and release Provider Name and its member(s) from any and all liability which may occur from my decision not to accept their recommendation.

____I accept transport only and refuse all treatment and/or specific treatments which they may render. I have been advised of the possible consequences that may result from the decision not to accept further treatment, and release City of Hutchins and its member(s) from any and all liability that may occur. (Note treatment refused in narrative.)

As a competent adult, I fully understand all of the above, and I am capable of making a rational decision on my behalf.

Witness:_____ Date:_____

EMS Assessment

___Patient was AAO x 3
___Patient denied ETOH or drug use
___Patient denied suicidal/homicidal ideation

Crew Signature:_____

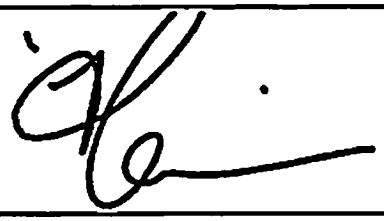
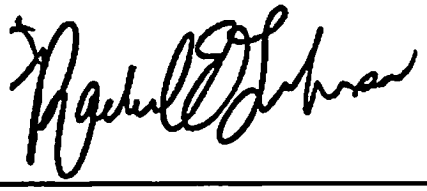
Electronically Signed

Harvill, William P (EMT-P) Crew #1
Pressler, Terry D (EMT-P) Crew #2

Patient Name: McCollum, Larry | Incident Date: 07-22-2011

City of Hutchins
321 North Main St.
HUTCHINS, TX 75141
972-225-3311

AMBULANCE RECORD

Signatures	
	Patient Representative In Custody Law Enforcement
Signatures	
	Facility Representative

Electronically Signed

Harvill, William P (EMT-P) Crew #1 Pressler, Terry D (EMT-P) Crew #2

Patient Name: McCollum, Larry | Incident Date: 07-22-2011

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

STEPHEN McCOLLUM, and SANDRA McCOLLUM, individually, and STEPHANIE KINGREY, individually and as independent administrator of the Estate of LARRY GENE McCOLLUM, PLAINTIFFS	§	
v.	§	CIVIL ACTION NO. 4:14-cv-3253 JURY DEMAND
BRAD LIVINGSTON, JEFF PRINGLE, RICHARD CLARK, KAREN TATE, SANDREA SANDERS, ROBERT EASON, the UNIVERSITY OF TEXAS MEDICAL BRANCH and the TEXAS DEPARTMENT OF CRIMINAL JUSTICE. DEFENDANTS	§	

Plaintiffs' Consolidated Summary Judgment Response Appendix

EXHIBIT 60

Patient Name: McCollum, Larry Gene (MRN: 4493765)

PARKLAND HEALTH & HOSPITAL SYSTEM ADMISSION/REGISTRATION FACESHEET

Admit/Appt Department: NINE NORTH MEDICAL ICU
Admit Dx/Chief Complaint:
Malignant Hyperthemia,Shock
Patient Notice:
Admit Date: 7/22/2011
Advance Directive: No
Discharge Date: 7/29/2011

MRN #: 4493765
HAR #: 609275275
CSN #: 328148327
Privacy Notice: Acknowledgement

ISO/INFECTION INFO
Isolation:
Infection:

Attend: 041809 (Terada, Lance S.)
PCP:

PATIENT INFORMATION
MCCOLLUM,LARRY GENE

4022 E Harris 9
Waco
Dallas TX 76705

County: DALLAS
Home Phone: 972-225-1304 (Temp)

No relevant phone numbers on file.

Alias: RHO,W

DOB: 4/4/1953 (58 yrs)
Marital Status: Single

Sex: Male

Race: White

EMERGENCY NOTIFICATION
Extended Emergency Contact Information

Emergency Contact #1
Name: CRANE,JERAMI
Address: 4724 E SIDE AVE
Home Phone Number: 214-824-9852
Work Phone Number: 214-000-0000
Relation: Friend

Emergency Contact #2
Name: MCCOLLUM,TERRY
Address: 116 W CARNES
Home Phone Number: 254-662-3741
Relation: Brother

GUARANTOR INFORMATION
MCCOLLUM,LARRY GENE
1500 E Langdon Rd
Dallas, TX 75241
Work Phone:

Financial Class: Charity
Relationship: Self
Sex: Male

PRIMARY INSURANCE
FEDERAL/OTHER INMAT*
301 University Blvd
Galveston, TX 77550-1008
Phone: 409-747-2645

Subscriber: MCCOLLUM,LARRY GENE
Relationship: Self
Cvg Group #:
Subscriber #: 1721640

SECONDARY INSURANCE

Subscriber:
Relationship:
Cvg Group #:
Subscriber #:

Phone:

EMPLOYER INFORMATION
Employer:
No address on file.
PRINT DATE: 9/12/2011

A20

Patient Name: McCollum, Larry Gene (MRN: 4493765)

Hospital Encounter Summary Report

Parkland Health & Hospital System
5201 Harry Hines Blvd
Dallas, Texas 75235
214-590-8000

Room/Bed	Name	MRN	Admit Date	Att Prov	HAR	DOB	Age	Sex
911-1	McCollum, Larry Gene	4493765	7/22/11	Lance S. Terada, MD	609275	4/4/1953	58 year old	M

Admission Information - Hospital Account/Patient Record

Arrival Date/Time:	07/22/2011 0400	Admit Date/Time:	07/22/2011 0400	IP Adm. Date/Time:	07/22/2011 0706
Admission Type:	Emergent	Admission Source:	Police/prisoner	Admit Category:	Emergency
Means of Arrival:	Ambulance	Primary Service:	Medicine	Secondary Service:	None
Transfer Source:	None	Service Area:	Phhs Service Area	Unit:	Nine N Medical Icu
Admit Provider:	Chet Schrader, MD	Attending Provider:	Lance S. Terada, MD	Referring Provider:	None

Isolation

No Isolation

Admission Diagnoses

Malignant Hyperthemia,Shock

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
07/29/2011 0233	Expired	Expired	None	Nine N Medical Icu

Treatment Team

Provider	Role	From	To
Chet Schrader, MD	Admitting Provider	N/A	07/22/11 0400
Chet Schrader, MD	Attending Provider	07/22/11 0424	07/22/11 0834
Lance S. Terada, MD	Attending Provider	07/22/11 0716	N/A
Jonathan Martin Hopkins, DO	Resident	07/22/11 0422	07/22/11 0723
Pulmonary Micu Iii Team	Pulmonary/MICU III Team	07/22/11 0716	N/A
Joseph Young, DO	Resident	07/22/11 0723	N/A
Craig M Davis, MS IV	Medical Student	07/25/11 0823	N/A

Allergies as of 7/29/2011

Date Reviewed: **3/6/2007** Reviewed By: **Thresiamma Kurian**

No Known Allergies

Problem List as of 7/29/2011

Never Reviewed

	Noted - Resolved	Last Modified
Malignant hyperthemia	7/22/2011 - Present	7/29/2011
	Entered by Kevin Ross Davidson, MD	
Shock	7/22/2011 - Present	7/29/2011
	Entered by Kevin Ross Davidson, MD	
Acute renal failure	7/22/2011 - Present	7/29/2011
	Entered by Kevin Ross Davidson, MD	
Rhabdomyolysis	7/22/2011 - Present	7/29/2011
	Entered by Kevin Ross Davidson, MD	

ED Arrival Information

Patient Name: McCollum, Larry Gene (MRN: 4493765)

ED Arrival Information (continued)

Expected	Arrival	Acuity	Means of Arrival	Escorted By	Service	Admission Type	Arrival Complaint
-	**7/22/2011 4:00 AM**	**ESI Level 2**	**Ambulance**	**EMS**	**Medicine**	**Emergent**	**Seizure**

Chief Complaint

None

Diagnoses

Diagnosis	User	Time	Action
Malignant hyperthemia [995.86S]	Kevin Ross Davidson, MD	Fri Jul 22, 2011 7:02 AM	Add
Shock [785.50G]	Kevin Ross Davidson, MD	Fri Jul 22, 2011 7:02 AM	Add
Status post PICC central line placement [V45.89AR]	Lisa Sue Thornton, RN	Mon Jul 25, 2011 10:47 AM	Add
Malignant hyperthermia [995.86]	Sylvia Choice	Mon Jul 25, 2011 2:57 PM	Add

Discharge Medication List as of 7/29/11 02:36 AM

CONTINUE these medications which have NOT CHANGED

	Details
acetaminophen 325 mg tablet	Take 325 mg by mouth every 4 hours as needed., Historical Med

Class: Historical Med

Home Medications

	Active?	Last Dose	Informant	Start Date	End Date	Provider	LT
AVEENO SHOWER & BATH EX otc as directed Associated Diagnoses: --				03/06/07	--	Jennifer L. Lakowsky-Brueckner, FNP	
BENADRYL 25 MG OR CAPS continue as instructed Associated Diagnoses: --				--	--	Provider Na	
ETODOLAC 400 MG OR TABS bid prn Associated Diagnoses: --				08/05/06	--	Bradley M. Richards, PA-C	
LASIX 20 MG OR TABS bid Associated Diagnoses: --				08/05/06	--	Bradley M. Richards, PA-C	
POTASSIUM CHLORIDE CR 10 MEQ OR TBCR 1 tab daily Associated Diagnoses: --				08/05/06	--	Bradley M. Richards, PA-C	
acetaminophen 325 mg tablet Take 325 mg by mouth every 4 hours as needed. Associated Diagnoses: --		Unknown		--	--	Provider Na	

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes

ED Notes signed by Rachael Marie Doak, RN at 07/22/11 0408

Author:	Rachael Marie Doak, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0408	Note Time:	07/22/11 0401		

Pt here via EMS from jail for seizures. Pt febrile. Pt was found by prisoners to be having seizures when EMS arrived pt was noted to be having seizures for unknown length of time. Placed on cardiac monitor with cont pulse ox MD Hopkins and MD Schrader at bedside.

Electronically Signed by Rachael Marie Doak, RN at 07/22/11 0408

ED Notes signed by Rachael Marie Doak, RN at 07/22/11 0409

Author:	Rachael Marie Doak, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0409	Note Time:	07/22/11 0408		

Ice bags placed on axilla, RSI to bedside. Per MD Schrader no reaction to sternal rub.

Electronically Signed by Rachael Marie Doak, RN at 07/22/11 0409

ED Notes signed by Rachael Marie Doak, RN at 07/22/11 0409

Author:	Rachael Marie Doak, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0409	Note Time:	07/22/11 0409		

RT to bedside for RSI. Cardiac monitor on with cont pulse ox.

Electronically Signed by Rachael Marie Doak, RN at 07/22/11 0409

ED Notes signed by Rachael Marie Doak, RN at 07/22/11 0411

Author:	Rachael Marie Doak, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0411	Note Time:	07/22/11 0410		

Per report from EMS pt had seizure and fell off of his bunk at jail.

Electronically Signed by Rachael Marie Doak, RN at 07/22/11 0411

ED Notes signed by Rachael Marie Doak, RN at 07/22/11 0411

Author:	Rachael Marie Doak, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0411	Note Time:	07/22/11 0411		

RT at bedside for intubation, RT bagging pt at this time.

Electronically Signed by Rachael Marie Doak, RN at 07/22/11 0411

ED Provider Notes signed by Chet Schrader, MD at 07/22/11 0440

Author:	Chet Schrader, MD	Service:	(none)	Author Type:	Attending
Filed:	07/22/11 0440	Note Time:	07/22/11 0425		

No chief complaint on file.

HPI Comments: 58 yo M with unknown PMHx p/w ?seizure while in processing at jail. Per inmate witnesses, +seizure activity ~1 hour PTA. EMS states took ~1 hour to get into patient and since patient has been completely unresponsive with agonal respirations. No known trauma. Unknown pmhx or circumstances during event.

All Notes (continued)

The history is provided by the EMS personnel and the police. The history is limited by the condition of the patient.

No current facility-administered medications on file.

No current outpatient prescriptions on file.

Allergies not on file

No past medical history on file.

History

Substance Use Topics

- Smoking status: Not on file
- Smokeless tobacco: Not on file
- Alcohol Use: Not on file

Review of Systems

Unable to perform ROS: intubated

BP 117/81 | Pulse 122 | Temp(Src) 41.1 °C (106 °F) (Tympanic) | Resp 18 | SpO2 95%

Physical Exam

Nursing note and vitals reviewed.
Constitutional: He appears toxic. He appears ill.
HENT:
Head: Normocephalic and atraumatic.
Mouth/Throat: Oropharynx is clear and moist.
Eyes: Right pupil is reactive. Left pupil is reactive.
Neck: Normal range of motion. Neck supple.
Cardiovascular: Tachycardia present. Exam reveals distant heart sounds.
Diminished heart sounds
Pulmonary/Chest: He is in respiratory distress **(agonal respirations)**. He has rhonchi in the right upper field, the right middle field, the right lower field, the left upper field, the left middle field and the left lower field.
Abdominal: Soft. He exhibits distension. No tenderness.
Morbidly obese
Musculoskeletal: He exhibits no edema.
Neurological: He is unresponsive. GCS eye subscore is 1. GCS verbal subscore is 1. GCS motor subscore is 1.
Negative dolls, no corneal reflex, no gag, no tone to extremities with stimulation/pain.

Initial ED Plan of Care:
58 yo M presents unresponsive -- unknown etiology; will r/o sepsis, ACS, ICH; intubated for airway protection

Electronically Signed by Chet Schrader, MD at 07/22/11 0440

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

ED Notes signed by Chet Schrader, MD at 07/22/11 0441

Author:	Chet Schrader, MD	Service:	(none)	Author Type:	Attending
Filed:	07/22/11 0441	Note Time:	07/22/11 0440		

See H&P

Electronically Signed by Chet Schrader, MD at 07/22/11 0441

ED Notes signed by Rachel Elizabeth Ledger, RN at 07/22/11 0512

Author:	Rachel Elizabeth Ledger, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0512	Note Time:	07/22/11 0506		

0447 Pt pressure continues to decrease to low SBP 50s. Dopamine started on 20mcg/min per Dr. Hopkins order.
0453 Pt SBP increase to 80s.
0457 Pt taken to CT scan with RT and RN on continuous cardiac monitor. With emergency equipment.
0505 Central line kit at pt bedside. Preparing for insertion. Pt is now tachycardiac from 150-200. BP increase to 90/48.

Electronically Signed by Rachel Elizabeth Ledger, RN at 07/22/11 0512

ED Notes signed by Rachel Elizabeth Ledger, RN at 07/22/11 0514

Author:	Rachel Elizabeth Ledger, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0514	Note Time:	07/22/11 0513		

Dopamine decrease to 10mcg/min per Dr. Schraeder order.

Electronically Signed by Rachel Elizabeth Ledger, RN at 07/22/11 0514

Progress Notes signed by Abelardo Alfonso Martinez-Rumayor, MD at 07/22/11 0523

Author:	Abelardo Alfonso Martinez-Rumayor, MD	Service:	Internal Medicine	Author Type:	Fellow
Filed:	07/22/11 0523	Note Time:	07/22/11 0513		
Related Notes:	Cosigned by: Tayo A. Addo, MD filed at 08/12/11 1355				

Interventional Cardiology Note

Evaluated patient after STEMI cath lab activation called by ED. He is a 58M without currently known medical history, incarcerated who about 1hr prior to presentation was noted to have seizure-like activity and syncope in jail, he was brought in to the PMH ED by ambulance, on arrival he was noted to be unresponsive, agonal breathing, weak pulses with significant hypotension and sinus tachycardia to 120's, he was also noted to be hyperthermic with a temp of 41-43 C while in-house. An EKG was noted to have diffuse ST depressions 2mm V2-V6 and D1,D2 with ST elevation 1mm in AVR. Cath lab was activated while patient sent for stat Head CT, preliminary read is negative for IC bleed but has evidence of diffuse ischemia. He was started on peripheral IV dopamine and is currently undergoing CVL access with plans for hypothermia protocol.
Based on current clinical presentation it is unclear what the initial insult was that caused this patient's initial syncope, his EKG is also more suggestive of diffuse hypoperfusion rather than acute coronary syndrome. After discussion with interventional attending we believe the best course of action is to continue the medical management and work up for the patient to elucidate the etiology of his initial insult, extent of CNS involvement and cause of hyperthermia, therefore cath lab has been deactivated for the moment.

Please call with questions, CCU team in ED evaluating patient as well.
Pager 822-3001

Electronically Signed by Abelardo Alfonso Martinez-Rumayor, MD at 07/22/11 0523

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

ED Notes signed by Rachel Elizabeth Ledger, RN at 07/22/11 0545

Author:	Rachel Elizabeth Ledger, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0545	Note Time:	07/22/11 0544		

Pt SBP increase to 170s. BP recheck, SBP is 160s. Dopamine decrease to 5mcg/min.

Electronically Signed by Rachel Elizabeth Ledger, RN at 07/22/11 0545

ED Notes signed by Rachel Elizabeth Ledger, RN at 07/22/11 0546

Author:	Rachel Elizabeth Ledger, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0546	Note Time:	07/22/11 0545		

Dr. Hopkins attempt to obtain arterial line with ultrasound on right wrist.

Electronically Signed by Rachel Elizabeth Ledger, RN at 07/22/11 0546

ED Notes signed by Rachel Elizabeth Ledger, RN at 07/22/11 0612

Author:	Rachel Elizabeth Ledger, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0612	Note Time:	07/22/11 0611		

DR. Hopkins Attempting LP. Unsuccessful attempts x2.

Electronically Signed by Rachel Elizabeth Ledger, RN at 07/22/11 0612

ED Notes signed by Rachel Elizabeth Ledger, RN at 07/22/11 0625

Author:	Rachel Elizabeth Ledger, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0625	Note Time:	07/22/11 0624		

Pt SBP continues to drop to low 60s. Dr. Hopkins notified. Pharmacy called for levophed. Femoral arterialline to pt bedside.

Electronically Signed by Rachel Elizabeth Ledger, RN at 07/22/11 0625

ED Notes signed by Rachel Elizabeth Ledger, RN at 07/22/11 0640

Author:	Rachel Elizabeth Ledger, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0640	Note Time:	07/22/11 0638		

Attempting to obtain femoral arterial access x2 Levophed infusing. 3rd NS bolus infusing with pressure bag.

Electronically Signed by Rachel Elizabeth Ledger, RN at 07/22/11 0640

ED Notes signed by Rachel Elizabeth Ledger, RN at 07/22/11 0700

Author:	Rachel Elizabeth Ledger, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0700	Note Time:	07/22/11 0659		

Unsuccessful attempt of femoral arterial line.MICU team at pt bedside.

Electronically Signed by Rachel Elizabeth Ledger, RN at 07/22/11 0700

ED Notes signed by Rachel Elizabeth Ledger, RN at 07/22/11 0712

Author:	Rachel Elizabeth Ledger, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0712	Note Time:	07/22/11 0515		
Related Notes:	Original Note by: Rachel Elizabeth Ledger, RN filed at 07/22/11 0527				

All Notes (continued)

Unsuccessful attempt at arterial line insertion.
0517 Dr. Hopkins at pt bedside to insert central femoral line. Time out complete. PT HR slightly decrease, BP increase. Ice packs on pt.

Electronically Signed by Rachel Elizabeth Ledger, RN at 07/22/11 0712

ED Notes signed by Rachel Elizabeth Ledger, RN at 07/22/11 0715

Author:	Rachel Elizabeth Ledger, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0715	Note Time:	07/22/11 0645		

120cc of ice water gastric lavage. OG clamped.

Electronically Signed by Rachel Elizabeth Ledger, RN at 07/22/11 0715

ED Notes signed by Rachel Elizabeth Ledger, RN at 07/22/11 0716

Author:	Rachel Elizabeth Ledger, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 0716	Note Time:	07/22/11 0411		
Related Notes:	Original Note by: Rachael Marie Doak, RN filed at 07/22/11 0415				

0411 20mg etomidate given by Maury RN.
0412 100mg of succinylcholine given by Maury RN.
0413 MD Hopkins attempting intubation. RT at pt bedside. Visualization of chords.
Pt intubated. Positive color change on end Co2. Bilateral breathsounds.
ETT 8.0 24cm at the teeth. Pt being currently bagged. CXR ordered.

Electronically Signed by Rachel Elizabeth Ledger, RN at 07/22/11 0716

Progress Notes signed by Kevin Ross Davidson, MD at 07/22/11 0813

Author:	Kevin Ross Davidson, MD	Service:	Pulmonary Diseases	Author Type:	PGY 3
Filed:	07/22/11 0813	Note Time:	07/22/11 0727		
Related Notes:	Original Note by: Kevin Ross Davidson, MD filed at 07/22/11 0738				

Brief MICU Note:

Middle aged man presented in early AM hours after reported seizure like activity. Pt initially profoundly hypertensive ~200/150, was intubated for decreasing responsiveness in ER. Has been febrile to 43° (109.4°F). Pt subsequently decompensated and has become hypotensive. Now on dopamine 15 and levophed 40. Admit to MICU for shock, malignant hyperthermia. Possible NMS. Differential also includes heat stroke, bacterial meningitis, serotonin syndrome, thyrotoxicosis, profound sepsis. I have spoken with Dr Pennant, anesthesiology regarding concern from MH. He advises rapid dantrolene administration. We will place rectal thermometer and rapidly cool

Davidson x4099

Electronically Signed by Kevin Ross Davidson, MD at 07/22/11 0813

H&P signed by Kevin Ross Davidson, MD at 07/22/11 0908

Author:	Kevin Ross Davidson, MD	Service:	Pulmonary Diseases	Author Type:	PGY 3
Filed:	07/22/11 0908	Note Time:	07/22/11 0818		
Related Notes:	Cosigned by: Lance S. Terada, MD filed at 07/25/11 0744				

MICU Team III History & Physical:

CC: S/p seizure at prison

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

Reason for ICU admission: Unresponsiveness, intubated, malignant hyperthermia

HPI: 58 year-old Caucasian male presented from prison after being witnessed to have a seizure while in common area. There are no details to the patient's clinical course leading up to his seizure and he has no known history of epilepsy. He reportedly has been in this prison for only 4 days and was recently at another jail facility. His jail is a non-air conditioned facility. His seizure occurred ~0300 hours and he was brought to Parkland by EMS. He was noted to be markedly febrile to 43° and with decreased responsiveness. In the ER he was initially hypertensive ~200/150, he had no gag, cough, or grimace and was completely unresponsive. The decision was made to intubate and he was given etomidate and succinylcholine. He was intubated without diffculty and a right femoral TL and right radial arterial line were both placed. His blood pressure decompensated and he was started on dopamine and levophed at high levels. Attempts were made to cool him with ice water NG lavage and packing his groin and axillae with ice packs.

ROS: Unable to obtain, patient unresponsive and intubated

PMH: Hypertension: managed on hydrochlorothiazide
Major depression
Diabetes mellitus (per correctional facility intake form)
Arthritis

Allergies: Unknown

Medications: HCTZ 25mg daily
Previously on 0.1mg clonidine PRN

Family History: Family history of unspecified cancer, diabetes, heart disease, HTN,
Social History: Incarcerated in prison for uncertain offense. No known history of drug or alcohol abuse.

Physical Exam:
VS: T 43° (109.4°) | HR 116 | RR 20 vent | BP 198/146 --> 76/51 | SpO2: 95% | Wt: 150kg (330lbs)
GEN: Obese caucasian male, intubated, supine with ice packs in grion and armpits, unresponsive
HEENT: Supple neck, no meningismus, unresponsive pupils,
CARDIAC: Distant, unable to auscultate any heart sounds, unable to appreciate JVP
CHEST: Intubated, clear in apices
ABD: Obese, soft, unable to assess for HSM
GU: Normal appearing genitalia, no evident loss of bowel or bladder function.
NEURO: Unresponsive, fixed equal pupils, unrespsonsive to light, no rigidity
EXT: No rigidity, no pedal edema, +onychomycosis
SKIN: Cool, dry

Labs:

NA	130*	7/22/2011
K	3.4*	7/22/2011
CL	93*	7/22/2011
CO2	20*	7/22/2011
ANIONGAP	17*	7/22/2011
BUN	39*	7/22/2011
CREATININE	2.69*	7/22/2011
GLUCOSE	167	7/22/2011
WBC	7.56	7/22/2011
HGB	14.3	7/22/2011
HCT	41.8	7/22/2011
MCV	93.1	7/22/2011
MCH	31.8	7/22/2011
PLT	136*	7/22/2011
AST	71*	7/22/2011
ALT	33	7/22/2011

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

ALKPHOS	40	7/22/2011
BILITOTAL	0.5	7/22/2011
LIPASE	65*	7/22/2011
ALB	3.4*	7/22/2011

Imaging:
CXR Intubated, cardiomegaly, blurred cardiomediastinal silhouette, no effusion on right, no apparent infiltrates
CT Head: No acute findings, no bleed or apparent mass lesion

EKG: Global ST depressions, TWI. Sinus tachycardia at 120. Borderline QRS at 102. QTc 452
TTE: Pending

Problem List:
1. Malignant hyperthermia
2. Rhabdomyolysis
3. Acute renal failure
4. Global ST depressions
5. Unwitnessed seizure

Assessment & Plan:
58 yo M presenting from prison after report of generalized seizure. On presentation, the patient has profound hyperthermia, acute renal failure, rhabdomyolysis, shock, and decreased responsiveness. The etiology of his shock and fever is unknown. His differential diagnosis includes heat stroke, profound sepsis, NMS, status epilepticus, serotonin syndrome, hypothalamic CVA, bacterial meningitis or thyrotoxicosis. He is empirically covered for sepsis and bacterial meningitis with ceftriaxone and vancomycin. He has no apparent seizure activity but we will plan for EEG to eval for subclinical seizures. We will give empiric cyproheptadine and dantrolene for concern of NMS/serotonin syndrome. Aggressive control of fever with ice water lavages and ice packing.

Malignant hyperthermia:
+Cooling blanket, ice water NG lavage, ice packs, foley lavage
+Monitor rectal probe
+Consider for Alsius cooling cordis if unable to cool
+Dantrolene 250mg IV x1, cryptoheptaine 12mg PO

Shock:
+Supportive hemodynamics, ordered additional 4L LR bolus, continue levophed
+Consider empiric steroids for hypotension unresponsive to fluids and pressors
+Echocardiogram given global ST depressions
+Asa 325mg given global ST depressions and concern for ACS risk factors

Neurologic status:
+Check NSE within 24 hours
+EEG to evaluate for subclinical seizures
+All sedation held, monitoring for improvement in neuro status

Rhabdomyolysis:
+Aggressive IVF, supportive hemodynamics

Prophylaxis: PPI, SCD's, hold
Code Status: Full code

Davidson x4099

All Notes (continued)

Electronically Signed by Kevin Ross Davidson, MD at 07/22/11 0908

Progress Notes signed by Ross Prater at 07/22/11 1026

Author: Ross Prater Service: (none) Author Type: Pastoral Care
Filed: 07/22/11 1026 Note Time: 07/22/11 1026

Spiritual Care Note

Patient's Name: W Rho
MRN: 4493765

Focus of Care: Patient

Faith Community: Unknown
Who Initiated Visit: Chaplain
Date Referral Received:
Time Received:
Length of Contact:
Response Category: Routine

Reason For Visit: Initial Rountine Visit;Length of Stay

Assessment: Hope Challenges;Patient/Family Unavailable for Care (pt intubated)

Plan of Care:

A.
Refer to:
Or
Discharge Refer to:
Date: Time:

B. Interventions: Sacraments/Ritual;Prayer

Electronically signed by:
ROSS PRATER
7/22/2011 1026

Electronically Signed by Ross Prater at 07/22/11 1026

Procedures signed by Marilyn L Sigman at 07/22/11 1149

Author: Marilyn L Sigman Service: (none) Author Type: Neurodiagnostic Technologist
Filed: 07/22/11 1149 Note Time: 07/22/11 1149

Procedure Orders:
1. EEG [118170989] ordered by Kevin Ross Davidson, MD at 07/22/11 0917

The EEG procedure has been completed and the results will be available within 24 hours. Inpatient results will be faxed to the patient's inpatient unit. Outpatient results will be faxed to the referring MD/clinic. Please call the Neurophysiology department at 214-590-8334 for additional information.

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

Electronically Signed by Marilyn L Sigman at 07/22/11 1149

H&P signed by Lance S. Terada, MD at 07/22/11 1529

Author: Lance S. Terada, MD Service: Internal Medicine Author Type: Attending
Filed: 07/22/11 1529 Note Time: 07/22/11 1513
Related Notes: Original Note by: Lance S. Terada, MD filed at 07/22/11 1528

Pulmonary Attending
I reviewed and examined Mr Rho with Dr. Davidson and I concur with the findings and plans recorded. 58 yo WF admitted from jail with hx of having been tx from one jail to a local cell 4 d ago. Cell is not air conditioned, large area shared by >200 inmates. He apparently had a sz, and was brought here and found to have temp 43C, hypertensive syst 200, and unresponsive. Only known med was HCTZ. Intubated, packed on ice, and tx to MICU.
PH HTN, depression.
SH incarcerated.
Exam MAP 70 on NE 38 ug/min. now unresponsive, pupils 2 mm sluggish, +OC reflex, neck supple. Core temp down to 38.3C now. Hands and feet are cool and dry. Lungs clear, heart reg and distant. abd very obese, soft. CXR no clear infiltrates.
Labs reviewed, AKI, rhabdo, gap acidosis, early DIC.

1. Hyperthermia. Unclear etiology. By exam, c/w heat stroke with cool clamped extremities (not on ice). He has been incarcerated, but if meds were accessed, could be c/w NMS or serotonin syndrome, though rhabdo and extreme hyperthermia more consistent with former. He has a modest amount of diarrhea now but not previously. Doubt malignant hyperthermia, as sux was given after arrival. No evidence for endocrinopathy or CNS cause. Will tx supportively with volume infusion, pressors as needed, ventilatory support, and external cooling as needed. Cont cyproheptidine x 24 h, d/c dantrolene for now. Also no evidence for CTD. Will check smear for evidence of TTP, though doubt.
2. AKI, likely dehydration, possibly ATN from prolonged hypoperfusion.
3. Rhabdo. IVF.
4. Abn mental status as above.
5. Hemodynamic shock. Likely 2/2 hyperthermia, will pan cx and cover with antibx for possible sepsis.
6. Seizure. Likely also 2/2 hyperthermia, EEG r/o akinetic status.

Lance Terada, MD

Electronically Signed by Lance S. Terada, MD at 07/22/11 1529

Progress Notes signed by Barbara E. McElroy at 07/22/11 1651

Author: Barbara E. McElroy Service: (none) Author Type: Pastoral Care
Filed: 07/22/11 1651 Note Time: 07/22/11 1649

Spiritual Care Note

Patient's Name: W Rho
MRN: 4493765

Focus of Care: Both wife and daughter were at Pt's bedside. Wife of about 1 year provided information regarding address, etc.

Faith Community: Baptist
Who Initiated Visit: Nurse
Date Referral Received:07/22/11
Time Received:15:30
Length of Contact:20 min
Response Category: Urgent

Reason For Visit: Family Care

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

Assessment: Sharing Spiritual Journey

Goals: Experience Supportive Presence;Feels Connected with Holy;Facilitate Open Communication in the Family

Plan of Care:

A. Visit at least once each 24 hours

B. Interventions: Supportive Dialogue/Empathic Listening;Prayer;Empathic Listening;Explored Family Resources/ Spiritual Resources

Electronically signed by:
BARBARA E. MCELROY
7/22/2011 1649

Electronically Signed by Barbara E. McElroy at 07/22/11 1651

Nurses Notes signed by Marian Ballena Raygon, RN at 07/22/11 1953

Author:	Marian Ballena Raygon, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/22/11 1953	Note Time:	07/22/11 1850		
Related Notes:	Original Note by: Marian Ballena Raygon, RN filed at 07/22/11 1857				

July 22, 2011, 1850
0805 report received from er rn (kelly d).
0840 pt arrived to unit, c levo and dopamine gtt on (dopamine gtt expired but per md davidson: ok to cont c dopamine gtt as previously ordered for now), situated in rm. Introduced self to pt, explained rn activities and poc. Pt assessment completed, please see all areas of pt documentation. All LDAs will be assessed q4h, complete documentation done on initial assessment, afterwards will document changes only. Pt on ventilator (ett), no eye opening, very weak withdraw from pain via bue, no other movement noted in all extremities, uta orientation/strenght/motor.
0900 poc initiated.
0928 md davidson at bs asssessing pt
0942 md davidson and md raghavan at bs roundind, assessing pt
1300 md davidson notified of urine output <30ml x2hr (LR boluses ordered per md davidson), also notified of unable to withdraw gastric lavage volume (max ~30ml out) (per md davidson: ok to cont c gastric lavages)
1630 md jarvie at bs shown of small amount of grv (coffee-ground like), also notified of urine output remaining inadequate, no new orders received, Will cont to monitor pt and document changes.
July 22, 2011, 1953
1922 Report given to oncoming rn (claudia f). Mar/kardex/labs/orders reviewed.

Electronically Signed by Marian Ballena Raygon, RN at 07/22/11 1953

Nurses Notes signed by Claudia S. Flores-Lopez, RN at 07/23/11 0712

Author:	Claudia S. Flores-Lopez, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/23/11 0712	Note Time:	07/22/11 1919		
Related Notes:	Original Note by: Claudia S. Flores-Lopez, RN filed at 07/23/11 0630				

July 22, 2011, 1919
Reprot received from off goingn nurse, labs, mar, and kardex reviewed, assuming care of pt.
July 22, 2011, 2005
Safety check and full assessment completed as per ICU standards. Pt is not sedated, doesn't follow commands, withraws

All Notes (continued)

to pain. ETT in place & vented on AC mode. Currently on bicarbonate, vasopressin and levophed gtt, nurse titrating as per dr's orders to keep map >65. Unable to obtain NIBP, physicians aware. hx of hyperthermia, colling blanket in place, performing gastric lavages as ordered to maintain temp<38. No s/s of distress, SOB or pain noted via alverno scale (alverno used, pt non responsive). Turned, POC reviewed, no changes made at this time. Family at the bedside, questions and concerns addressed appropriately. See flow sheet for more details. Will continue to monitor.
July 22, 2011, 2300
Dr. Davidson 54774 at the bedside, updated on pt status, labs reviewed, orders to increase Na bicarbonate gtt rate to 150cc/hr.Ca chloride to be ordered. Vasopressin stopped, levophed currently @1mcg/min, titrating as per physician orders.
July 23, 2011, 0018
0000-Full assessment completed as per ICU standards. Not febrile, cooling blanket off. Small dose of levophed. Pt withdraws to pain. No s/s of distress, SOB or pain via alverno scale. Turned, see flow sheet will continue to monitor.
July 23, 2011, 0200
Pt with closed eyes, no s/s of distress noted, turned, hands opened and positioned to maintain normal position.
July 23, 2011, 0330
Dr. Davidson 54755 at the bedside, updated on pt status. No orders at this moment, will get labs.
July 23, 2011, 0400
Pt completely reassessed as per Flow sheet, currently on Na bicarbonate @150cc/hr, no vasopressors required, pupils are more reactive, withraws to pain, doe snot follow commands. Temperature within normal range, no cooling blanket required. No s/s of distress, pain or SOB noted via alverno scale. See flow sheet for more details. Will continue to monitor.
July 23, 2011, 0629
0615 waiting for platelets to be sent, lab called. Order in process.
July 23, 2011, 0712
Report given to upcoming nurse, labs, mar and kardex reviewed, RN assuming care of pt.

Electronically Signed by Claudia S. Flores-Lopez, RN at 07/23/11 0712

Progress Notes signed by Carlos E. Girod, MD at 07/23/11 1000

Author: Carlos E. Girod, MD Service: Pulmonary Diseases Author Type: Attending
Filed: 07/23/11 1000 Note Time: 07/23/11 0849

MICU ATTENDING FOLLOW-UP AND CRITICAL CARE NOTE:
Admit Date: 7/22/2011.
I have seen and examined Mr. Larry Gene McCollum with Dr. Davidson and reviewed the note dated 7/23/2011. I concur with the history, physical exam, data, and assessment/plan as summarized. I have been at bedside coordinating care, reviewing imaging, and examining hemodynamics for this critically-ill patient for a total **Critical Care Time of 38 minutes**.

58 year-old man with witnessed seizure in jail who was brought in with marked fevers to 43° C felt to be environmental exposure. Cell is an non-airconditioned jail cell. He presented comatose on arrival and was intubated and cooled internally and externally. Developed MSOF and severe hyptension.

Overnight events are significant for now off pressors with improved temperature. He has MSOF with shock liver and renal failure. Decreased UOP less than 30 cc/hr last hour.

To my examination, Tm Temp (24hrs), Avg:37.1 °C (98.8 °F), Min:32.8 °C (91 °F), Max:39.4 °C (102.9 °F). RR 20. 92/55. Off levophed. Overbreathing vent. Acutely ill. On no sedation. Some response to noxious stimuli. Lungs reveal diminished at bases. Heart RRR. Comatose. Distant HS.

The CXR reveals CMG, LVH. No infilatretates.

Intake/Output Summary (Last 24 hours) at 07/23/11 0850
Last data filed at 07/23/11 0800

	Gross per 24 hour
Intake	12255.7 ml
Output	1556 ml

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

Net	10699.7 ml

Labs were reviewed and are significant for:
Lab Results: Vent Mode: Assist Control / FIO2 (%): 40 % / Vent rate (bpm): 26 bpm / Tidal Volume (mL): 600 mL / Vent PEEP (cm /H2O): 5 cm H20
PIP: 27 /

Component	Value	Date
PHART	7.39	7/23/2011
PCO2ART	18*	7/23/2011
PO2ART	208*	7/23/2011
HCO3ART	11*	7/23/2011
BEART	-12.8*	7/23/2011
O2SATART	100*	7/23/2011

Lab Results

Component	Value	Date
BUN	45*	7/23/2011
CREATININE	4.29* <--- 4.13 <-- 2.69	7/23/2011

Na+ 123

Lab Results

Component	Value	Date
WBC	5.82	7/23/2011
HCT	35.1*	7/23/2011
PLT	9*	7/23/2011

AST 1400
CPK 17,000

CK, TOTAL (Units/L)

Date	Value
7/23/2011	24331*
7/22/2011	17247*
7/22/2011	11787*

CK MB (ng/mL)

Date	Value
7/23/2011	88*
7/22/2011	60*
7/22/2011	4

Troponin T (ng/mL)

Date	Value
7/23/2011	0.27*
7/22/2011	0.28*
7/22/2011	0.27*

Assessment and Plan:
I have discussed management with Dr. Davidson. Mr. Larry Gene McCollum remains in the MICU with critical illness due to marked hyperthermia either due to environmental exposure vs neuroleptic malignant hyperthermia vs serotonin syndrome vs central fever. Head CT scan read as normal without lesions. He has MSOF with severe rhabdomyolysis, shock liver, and ARF. His neuro status is poor with concern for a stroke vs metabolic encephalopathy vs an anoxic injury (at jail passed out). Will consult Neurology. EEG yesterday was negative for status (non-convulsive). We are treating empirically with IV Abx, HCO3 gtt for rhabdomyolysis, and IV NAC for acute liver failure. He has severe DIC. Will discuss with renal service. Main issue is poor mental status with guarded neurological prognosis. Continue hyperventilation. Prognosis is poor. Continue support.

Carlos E. Girod, M.D.
MICU Attending

All Notes (continued)

Electronically Signed by Carlos E. Girod, MD at 07/23/11 1000

Progress Notes signed by Martin Mbugua at 07/23/11 1801

Author:	Martin Mbugua	Service:	(none)	Author Type:	Pastoral Care
Filed:	07/23/11 1801	Note Time:	07/23/11 1800		

Spiritual Care Note

Patient's Name: Larry Gene McCollum
MRN: 4493765

Focus of Care: Patient

Faith Community: Baptist
Who Initiated Visit: Chaplain

Length of Contact: 5 min
Response Category: Urgent

Reason For Visit: Follow Up

Assessment: Relationship with Holy;Religious/Spiritual Support

Goals: Experience Supportive Presence;Feels Connected with Holy

Plan of Care:

B. Interventions: Prayer

Electronically signed by:
Martin Mbugua
7/23/2011 1800

Electronically Signed by Martin Mbugua at 07/23/11 1801

Nurses Notes signed by Marian Ballena Raygon, RN at 07/23/11 1925

Author:	Marian Ballena Raygon, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/23/11 1925	Note Time:	07/23/11 0825		
Related Notes:	Original Note by: Marian Ballena Raygon, RN filed at 07/23/11 1859				

July 23, 2011, 0825
0752 Poc reviewed, no changes made at this time. Introduced self to pt, explained rn activities and poc. Pt assessment completed, please see all areas of pt documentation. All LDAs will be assessed q4h, complete documentation done on initial assessment, afterwards will document changes only. Pt on ventilator (ett), no eye opening, no follow, weak withdraw to pain via bue, noted no movement in ble, uta orientation/strenght/motor. PLT transfusion pending dt no blood consent available, md davidson aware and working on getting the consent.
July 23, 2011, 0910
Per md davidson: no sbt for today dt abnormal abg and need for bicarb gtt.

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

July 23, 2011, 1051
1047 md davidson at bs, notified of urine output remaining <30mls/hr (per md davidson: cont to monitor urine output), levo at 1mcg, temp 37.1, current lab results reviewed (no new orders received)
July 23, 2011, 1858
1800 pt transported to ct scan for ct of brain w/o contrast via bed, c rt and rn and bicarb and mucomyst gtt.
1830 pt back from CT, pt tolerated ct well, Will cont to monitor pt and document changes.
July 23, 2011, 1925
Report given to oncoming rn (megan r). Mar/kardex/labs/orders reviewed.

Electronically Signed by Marian Ballena Raygon, RN at 07/23/11 1925

All Notes

Nurses Notes signed by Megan Kristine Ruedebusch, RN at 07/24/11 0714

Author: Megan Kristine Ruedebusch, RN | Service: (none) | Author Type: Registered Nurse
Filed: 07/24/11 0714 | Note Time: 07/23/11 1945
Related Notes: Original Note by: Megan Kristine Ruedebusch, RN filed at 07/24/11 0432

July 23, 2011, 1945
1910 Report received from offgoing RN Marion. MAR and MD orders reviewed in Epic.
1930 Safety check completed.
July 23, 2011, 2033
2000 Initial assessment completed. See ICU flowsheet and ICU assess for assessment details.
July 23, 2011, 2053
2046 Labs drawn and sent.
July 24, 2011, 0028
7/23/11 2240 MD Bachim aware of pt lab results. No new orders received at this time.
7/24/11 0015 Pt reassessed. No acute changes from previous assessment.
July 24, 2011, 0327
0315 Labs drawn and sent.
July 24, 2011, 0431
0410 Pt reassessed. See ICU flowsheet and ICU assess for acute changes. Pt bathed; linens changed. Tolerated well; no acute events. MD Bachim aware of pt lab results. New orders received.
July 24, 2011, 0713
Report given to oncoming RN Marion. MAR and MD orders reviewed in Epic.

Electronically Signed by Megan Kristine Ruedebusch, RN at 07/24/11 0714

Progress Notes signed by Carlos E. Girod, MD at 07/24/11 1419

Author: Carlos E. Girod, MD | Service: Pulmonary Diseases | Author Type: Attending
Filed: 07/24/11 1419 | Note Time: 07/24/11 0845
Related Notes: Original Note by: Kevin Ross Davidson, MD filed at 07/24/11 1142

MICU / Pulmonary Team III Daily Note:

24 hour events: Remains off of or on minimal pressors, tube feedings started, minimal neurologic responses. Had head Ct which shows bilateral low densities in basal ganglia and internal capsules. Guards remain at bedside

Hospital Day:	3	
Drips:	Levophed	HELD
	Bicarbonate @ 100cc/hr	
Lines:	Rt fem TL	7/22
	Rt radial A-line	7/22
Antibiotics:	Ceftriaxone	D/c'd today after 2 days
	Vancomycin	D/c'd today after 2 days

AC: Vt 550 / f 16 / 40% / +5
7.51 / 23 / 176 / 18 / 100% (before vent changes)

VS: Tm 38.1° | HR 70-80 | RR 20 | BP 70-80 | SpO2: 100% | Wt: 159.5kg
I/O: +6.5 L | -1 L | Net: +5.5L
Chest: Course bilateral breath sounds, diminished at bases, no wheezes
Cardiac: Distant, unable to appreciate
Abd: Obese, soft, +foley/rectal tube
Neuro: Withdraws from some noxious stimuli with limited movement, otherwise overbreathes vent but no additional purposeful movement. Has late gag response.
Ext: Mottling of legs slightly improved from yesterday, no palpable feet pulses.

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

Medicines:

• insulin regular sliding scale 1-7 Units	1-7 Units	Q6H
• hydroxypropyl methylcellulose (ISOPTO TEARS) 0.5 % ophthalmic solution	1 Drop	PRN
• sodium chloride 0.9% infusion		CONTINUOUS
• acetaminophen (TYLENOL) oral solution DOSE: 650 mg	650 mg	Q4HR PRN
• norepinephrine (LEVOPHED) 32 mg in D5W 250 mL	5-200 mcg/min	TITRATE
• hydrocortisone sodium succinate (SOLUCORTEF) injection DOSE: 50 mg	50 mg	Q6H
• sterile water 1,000 mL with sodium bicarbonate 150 mEq infusion		CONTINUOUS
• pantoprazole (PROTONIX) injection DOSE: 40 mg	40 mg	Q24HR

Labs:

NA	128*	7/24/2011
K	3.2*	7/24/2011
CL	88*	7/24/2011
CO2	20*	7/24/2011
ANIONGAP	20*	7/24/2011
BUN	59*	7/24/2011
CREATININE	5.21*	7/24/2011
GLUCOSE	225*	7/24/2011
WBC	6.78	7/24/2011
HGB	10.9*	7/24/2011
HCT	30.2*	7/24/2011
MCV	86.5	7/24/2011
PLT	25*	7/24/2011

Imaging:

CXR P

CT Head: Bilateral low densities within the basal ganglia and internal capsules. The differential diagnosis includes hypoxic ischemia, osmotic demyelination syndrome, or toxicity.

TTE: LV function appears reduced, RA/RV both at least moderately dilated, decr RV function. Paradoxic septal motion. No regurgitation seen, no effusion.

Problem List:

1. Multi-organ dysfunction (ARF, shock liver, neurologic impairment)
2. Unresponsiveness
3. Acute renal failure
4. Rhabdomyolysis
5. Unwitnessed seizure

Assessment & Plan:

58 yo M presenting from prison after report of generalized seizure. On presentation, the patient had profound hyperthermia, acute renal failure, rhabdomyolysis, shock, and decreased responsiveness. The etiology of his shock and fever remain uncertain. In the last 24 hours he is no longer requiring pressors. He is normothermic and no longer requiring cooling methods. His neurologic recovery remains guarded

Resolving shock:

+Supportive hemodynamics, TTE shows right sided dysfunction, holding boluses
+Tapering empiric steroids which were added per Annane study
+Supportive care, levophed for recurrent hypotension, avoid boluses

Unresponsiveness:

+NSE pending, slight improvement in neuro function
+All sedation held, monitoring for improvement in neuro status
+EEG was neg for subclinical status

Malignant hyperthermia: Resolved and normothermic, monitoring closely. No longer on dantrolene or cyproheptadine
Rhabdomyolysis: Bicarbonate GTT
ATN: Supporting hemodynamics awaiting recovery
Prophylaxis: PPI, SCD's, hold

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

Code Status: Full code

Davidson x4099

MICU ATTENDING FOLLOW-UP NOTE:
Admit Date: 7/22/2011.
I have seen and examined Mr. Larry Gene McCollum with Dr. Davidson and reviewed the note dated 7/24/2011. I concur with the history, physical exam, data, and assessment/plan as summarized. Overnight events are significant for increased neurological activity. He is moving feet with some purpose. Opens eyes to sternal rub. Off dantrolene. Still with MSOF and critically-ill. He has some asynchroncy with ventilator.

To my examination, Tm Temp (24hrs), Avg:37.3 °C (99.2 °F), Min:37.1 °C (98.8 °F), Max:37.7 °C (99.9 °F). GA: Morbidly obese. Intubated. Moves sponmtaneously right > left side. Lungs reveal clear BS anteriorly. Heart RRR. The CXR reveals pending.

Intake/Output Summary (Last 24 hours) at 07/24/11 1414
Last data filed at 07/24/11 1400

	Gross per 24 hour
Intake	6474 ml
Output	1529 ml
Net	4945 ml

Labs were reviewed and are significant for:

Lab Results

Component	Value	Date
PHART	7.52*	7/24/2011
PCO2ART	24*	7/24/2011
PO2ART	233*	7/24/2011
HCO3ART	19*	7/24/2011
BEART	-2.0	7/24/2011
O2SATART	100*	7/24/2011

Lab Results

Component	Value	Date
BUN	59*	7/24/2011
CREATININE	5.33*	7/24/2011

Lab Results

Component	Value	Date
WBC	7.78	7/24/2011
HCT	31.5*	7/24/2011
PLT	21*	7/24/2011

Assessment and Plan:
I have discussed management with Dr. Davidson. Mr. Larry Gene McCollum remains in the MICU with critical illness due to hyperthermia due to environmental exposure vs malignant hyperthermia. He has a persistent neurological deficit off sedation but he is showing some improvement in spontaneous movement. CT repeat with LDA in the basal ganglia and internal capsule. His neurological prognosis is guarded. Will consult neurology if no improvement. His shock liver is stable with INR 1.7 and reduced AST. He has severe rhabdomyolysis and the CK is now 18,000. His pH is quite alkalotic and will switch from HCO3 drip to NSS. He has RV dysfunction and would avoid overload. UOP 40-50 cc/hr. He has MSOF. On IV NAC for liver injury. Continue aggressive support.

Carlos E. Girod, M.D.
MICU Attending

Mon Sep 12, 2011 4:08 PM

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

Electronically Signed by Carlos E. Girod, MD at 07/24/11 1419

Nurses Notes signed by Marian Ballena Raygon, RN at 07/24/11 1641

Author:	Marian Ballena Raygon, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/24/11 1641	Note Time:	07/24/11 0816		
Related Notes:	Original Note by: Marian Ballena Raygon, RN filed at 07/24/11 0953				

July 24, 2011, 0816
0742 Poc reviewed, no changes made at this time. Introduced self to pt, explained rn activities and poc. Pt assessment completed, please see all areas of pt documentation. All LDAs will be assessed q4h, complete documentation done on initial assessment, afterwards will document changes only. Pt on ventilator (ett), no eye opening, no follow, very weak withdraw to pain via bue, noted spont flickers on ble, uta orientation/motor/sensation/strenght.
July 24, 2011, 0950
0945 md holtz and md davidson at bs rounding, assessing pt, notified of pt status (bruising in lt groin area--possible from c-line attempts in ER, adequate urine output, no fever, PR interval =.20). ekg result reviewed by md davidson. Per md davidson: plan is to cont supportive care, decrease bicarb gtt, concentrate ivfluids, modify frequency of labs.
July 24, 2011, 1641
1630 Report given to oncoming rn (joychan j). Mar/kardex/labs/orders reviewed.

Electronically Signed by Marian Ballena Raygon, RN at 07/24/11 1641

Nurses Notes signed by Joychan P. Joseph, RN at 07/24/11 1922

Author:	Joychan P. Joseph, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/24/11 1922	Note Time:	07/24/11 1645		
Related Notes:	Original Note by: Joychan P. Joseph, RN filed at 07/24/11 1646				

July 24, 2011, 1645
1630 report received from off going RN
1645 safety check done.
July 24, 2011, 1921
1800 no change in condition, family at bedside, labs sent.
1920 report given to oncoming RN

Electronically Signed by Joychan P. Joseph, RN at 07/24/11 1922

Progress Notes signed by Victor V Machiano at 07/25/11 0430

Author:	Victor V Machiano	Service:	(none)	Author Type:	Pastoral Care
Filed:	07/25/11 0430	Note Time:	07/25/11 0430		

Spiritual Care Note

Patient's Name: Larry Gene McCollum
MRN: 4493765

Focus of Care: Other: Patient was asleep and was prayed for at bedside.Continue to visit during ICU stay.

Faith Community: Baptist
Who Initiated Visit: Chaplain
Date Referral Received:
Time Received:
Length of Contact:
Response Category: Routine

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

Reason For Visit: Follow Up

Assessment: Patient/Family Unavailable for Care

Goals: Experience Supportive Presence;Feels Connected with Holy

Plan of Care:
Follow Up Required?: Yes
A. Follow Up Time Frame: Other (Comment) (24 hour goal)
Refer to:
Or
Discharge Refer to:
Date: Time:

B. Interventions: Prayer

Electronically signed by:
VICTOR V MACHIANO
7/25/2011 0430

Electronically Signed by Victor V Machiano at 07/25/11 0430

Nurses Notes signed by Ana Marie Frederick, RN at 07/25/11 0718

Author: Ana Marie Frederick, RN Service: (none) Author Type: Registered Nurse
Filed: 07/25/11 0718 Note Time: 07/24/11 2006
Related Notes: Original Note by: Ana Marie Frederick, RN filed at 07/25/11 0312

July 24, 2011, 2006
1915 Report received and care assumed. Plan of care reviewed, no changes made at this time. Unable to elicit cough or gag reflex, primary team aware of neuro status.
July 25, 2011, 0124
Attempted TPA intracatheter for proximal port of C-line, still no blood return, but good flush. A-line dressing and tubing changed.
July 25, 2011, 0154
A line waveform was crisp at end of dressing change with positive blood return. Now A-line has extremely dampened waveform with difficult, extremely positional blood return. NIBP still correlates with cuff pressure. Circulation and pulses intact. Will notify primary team in AM.
July 25, 2011, 0310
Per lab, chemistry resulted, but for unknown reasons, results did not pull to EPIC. Printout of results sent up and placed in chart.
July 25, 2011, 0717
No other events overnight, report given to oncoming RN.

Electronically Signed by Ana Marie Frederick, RN at 07/25/11 0718

Procedures signed by Lisa Sue Thornton, RN at 07/25/11 1052

Author: Lisa Sue Thornton, RN Service: (none) Author Type: Registered Nurse
Filed: 07/25/11 1052 Note Time: 07/25/11 1051

July 25, 2011, 1051
for right picc palcement please see doc flow sheet. Thank you

Electronically Signed by Lisa Sue Thornton, RN at 07/25/11 1052

All Notes (continued)

Progress Notes signed by Lance S. Terada, MD at 07/25/11 1142

Author: Lance S. Terada, MD Service: Internal Medicine Author Type: Attending
Filed: 07/25/11 1142 Note Time: 07/25/11 0747
Related Notes: Original Note by: Jennifer Lynne Jarvie, MD filed at 07/25/11 0809

MICU / Pulmonary Team III Note:

24 hour events: Remains off of or on minimal pressors, tube feedings started, minimal neurologic responses. Had head Ct which shows bilateral low densities in basal ganglia and internal capsules. Guards remain at bedside

Hospital Day: 4
Drips: None
Lines: Rt fem TL 7/22
Rt radial A-line 7/22
Antibiotics: None - stopped yesterday

AC: Vt 550 / 16 / 40% / +5
7.51/26/130/100%

VS: Tm 37.8 Tc 37 82 103/67 23 100% vent
I/O: +370cc

General: unresponsive, vented
Chest: Course bilateral breath sounds, symmetric
Cardiac:Distant, unable to appreciate
Abd: Obese, soft, +foley/rectal tube
Neuro: Withdraws from some noxious stimuli with limited movement, otherwise overbreathes vent but no additional purposeful movement.
Ext: Mottling of legs slightly improved from yesterday, no palpable feet pulses. Hands and feet are warm with good cap refill.

Medicines:
Current Inpatient Medications

Medication	Dose	Frequency
• insulin regular sliding scale 2-12 Units	2-12 Units	Q6H
• lidocaine injection 1%	10 mL	PRN
• hydrocortisone sodium succinate (SOLUCORTEF) injection DOSE: 50 mg	50 mg	Q12H
• sodium chloride 0.9% infusion		CONTINUOUS
• hydroxypropyl methylcellulose (ISOPTO TEARS) 0.5 % ophthalmic solution DOSE: 1 Drop	1 Drop	PRN
• sodium chloride 0.9% infusion		CONTINUOUS
• acetaminophen (TYLENOL) oral solution DOSE: 650 mg	650 mg	Q4HR PRN
• norepinephrine (LEVOPHED) 32 mg in D5W 250 mL	5-200 mcg/min	TITRATE
• pantoprazole (PROTONIX) injection DOSE: 40 mg	40 mg	Q24HR

Labs:
Na 13
K 3.2
Cl 92
CO2 22
BUn 67
Creat 4.86
Ca 7.4 -> 8.6 corrected

All Notes (continued)

Phos 5.3
Mg 2.3

WBC 7.17
Hgb 11.0
Hct 31.3
Plt 28

LFt
Tbili 0.6
ALT 578 (downtrending)
AST 471 (downtrending)
Alk Phos 53

INR 1.3/PT 12.6

CK 12870 (downtrending)
B12 661

Imaging:
CXR: Increased opacities of bilat bases, widened mediastinum. Official read pending.

Problem List:

6. **Multi-organ dysfunction (ARF, shock liver, neurologic impairment)**
7. **Unresponsiveness**
8. **Hyperthermia**
9. **Acute renal failure**
10. **Rhabdomyolysis**
11. **Unwitnessed seizure**

Assessment & Plan:
58 yo M presenting from prison after report of generalized seizure. On presentation, the patient had profound hyperthermia, acute renal failure, rhabdomyolysis, shock, and decreased responsiveness. The etiology of his shock and fever remain uncertain. In the last 24 hours he is no longer requiring pressors. He is normothermic and no longer requiring cooling methods. His neurologic recovery remains guarded.

Resolving shock with Multiorgan Dysfunction:
-Supportive hemodynamics, TTE shows right sided dysfunction, holding boluses
-Tapering empiric steroids which were added per Annane study
-Supportive care, levophed ordered but has been off for >24 hours. Avoid boluses.

Unresponsiveness:
-NSE pending, slight improvement in neuro function. Responds to noxious stimuli and nonpurposeful movement.
-Has not required sedation.
-Monitoring for improvement in neuro status
-EEG was neg for subclinical status

Malignant hyperthermia: Resolved and normothermic, monitoring closely. No longer on dantrolene or cyproheptadine. No longer requiring cooling blanket or lavages.

Rhabdomyolysis: Bicarbonate GTT stopped. CK is downtrending. UOP has improved substantially, so giving fluids to replace UOP.

ATN: UOP with dramatic increase (post-ATN).
-Maintenance fluids (NS 50cc/hr) to keep net even or slightly net neg in setting of increased UOP and rhabdo, but echo showing RLV dysfunction.

Prophylaxis: PPI, SCD's

All Notes (continued)

Code Status: DNR

Jennifer Jarvie
Internal Medicine R1
x6852

Pulmonary Attending
I reviewed and examined Mr McCollum with Dr. Jarvie and I concur with the findings and plans recorded. He is nonresponsive. No sns of sz activity. +OC reflexes. CK decreasing, temp curve decreasing, afeb x 24 h. His hands and feet are now well perfused. Creat still elevated, most other labs improving. It is possible that he has a genetic predisposition for environmental heat stroke. Will look into ryanodine receptor genotyping or functional myocyte contracture assay. Await CNS recovery, cannot extubate at present.

Lance Terada, MD

Electronically Signed by Lance S. Terada, MD at 07/25/11 1142

Procedures signed by Lisa Sue Thornton, RN at 07/25/11 1256

Author: Lisa Sue Thornton, RN Service: (none) Author Type: Registered Nurse
Filed: 07/25/11 1256 Note Time: 07/25/11 1254

PICC Malposition Addendum

Date: 7/25/2011
Time: 1254

Type: right atrium
Action taken: retracted
Sterile technique: yes
Post reposition funciton:
- Aspirates: {yes
- Flushes: yes

Amount of flush instilled per port: 10 ml
Patient tolerance of procedure: well
Repositioned by: lisa thornton r.n. 7179
Secured with:stat lock
Amount of exposed catheter: 2.5 cm
Chest X-ray ordered: {no
Comments: bedside r.n. informed

Electronically Signed by:
LISA SUE THORNTON, RN

Electronically Signed by Lisa Sue Thornton, RN at 07/25/11 1256

Progress Notes signed by Kristi Click at 07/25/11 1614

Author: Kristi Click Service: (none) Author Type: Pastoral Care
Filed: 07/25/11 1614 Note Time: 07/25/11 1613

Spiritual Care Note

Patient's Name: Larry Gene McCollum
MRN: 4493765

Focus of Care: Patient
Pt was intubated, sedated & unavailable for care. Said a prayer at the bedside & spoke with the guards escorting him.

All Notes (continued)

Faith Community: Baptist
Who Initiated Visit: Chaplain

Length of Contact: 10 mins
Response Category: Routine

Reason For Visit: Follow Up

Assessment: Patient/Family Unavailable for Care

Goals: Experience Supportive Presence

Plan of Care:
Follow Up Required?: Yes
A. Follow Up Time Frame: Other (Comment) (24 hour ICU goal)

B. Interventions: Prayer

Electronically signed by:
Kristi Click
7/25/2011 1613

Electronically Signed by Kristi Click at 07/25/11 1614

Progress Notes signed by Wendi Campbell, RD, LD at 07/25/11 1906

Author:	Wendi Campbell, RD, LD	Service:	(none)	Author Type:	Dietitian
Filed:	07/25/11 1906	Note Time:	07/25/11 1856		

Nutrition Support Assessment
Pt seen and evaluated per protocol. See Adult Nutrition documentation flowsheet for full details. Chart and labs reviewed.
Lab Results

Component	Value	Date
NA	136	7/25/2011
K	3.1* (tx po)	7/25/2011
CO2	24	7/25/2011
CL	97*	7/25/2011
BUN	74*	7/25/2011
CREATININE	3.96*	7/25/2011
GLUCOSE	214*	7/25/2011
CALCIUM	7.5*	7/25/2011
MAG	2.3	7/25/2011
PHOS	5.2*	7/25/2011

Glucose POC (mg/dL)

Date	Value
7/25/2011	220
7/25/2011	279
7/25/2011	277
7/24/2011	280
7/24/2011	274
7/24/2011	248

Diet: TF:Nepro at 40 ml/hr; one beneprotein TID **Medications:** reviewed

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

GRV: <0-20 ml> **IVF:** NS at 50 ml/hr **BM/RT:** 500 ml

Assessment:

Pt malnourished PTA, at nutrition risk 2/2 Dx and morbid obesity. Appears to be tolerating current rate of tube feeding. Poor glycemic control with current insulin regimen and pt not at goal TF.

Plan:

Goal: Tolerance of tube feeding

1. Initial TF goal: Peptamen AF at 70 ml/hr with 2 beneprotein packets TID
2. Recommend insulin gtt
3. Treat electrolytes with IVPB

Electronically Signed by:
Wendi S. Campbell, RD,LD,CNSD

Electronically Signed by Wendi Campbell, RD, LD at 07/25/11 1906

Nurses Notes signed by Ashley M Dunnier, RN at 07/25/11 1926

Author: Ashley M Dunnier, RN Service: (none) Author Type: Registered Nurse
Filed: 07/25/11 1926 Note Time: 07/25/11 0955
Related Notes: Original Note by: Ashley M Dunnier, RN filed at 07/25/11 1754

July 25, 2011, 0955
0717 Report received from Ana Frederick, RN. Orders, mar, labs and kardex reviewed and verified.
0725 Safety check completed. Initial assessment done. Pt remains off sedation; not opening eyes or following commands. No response noted when central pain applied to trapezius but extension noted when nailbed pain applied. Corneal present; gag weak and no cough noted. Noted to be overbreathing ventilator. Remains off cooling blanket; transesophageal temp 37.5-37.9. No s/s pain or acute distress noted @ this time. See epic for further details. Will continue to monitor. POC reviewed and updated.
July 25, 2011, 1003
0725 Officers remain @ bedside.
0945 Phone consent obtained by PICC RN for PICC placement.
0950 Dr. Jarvie 56327 @ bedside for rounds with Dr. Terada 41809.
0957 Lisa Thorton, RN (PICC nurse) @ bedside for PICC placement; timeout performed.
July 25, 2011, 1033
1030 Vent changes made; see flowsheet.
July 25, 2011, 1101
1050 Right PICC double lumen placed; waiting for confirming CXR.
1058 Stat CXR @ bedside for Picc placement
July 25, 2011, 1121
1100 Tube feed tubing and feed changed per protocol. Waiting for PICC placement to be confirmed.
July 25, 2011, 1226
1130 Pt reassessed. Still has positive corneal reflexes; cough and gag noted to be absent when ETT in line suction passed down to carina without eliciting a cough or gag response. Noted to withdraw when pain applied to bilateral axilla but not trapezius. Withdrew bilateral upper extremities only to nail bed pain. No other changes noted @ this time. Pt son @ bedside; informed that Dr. Jarvie 56327 has updated pt's daughter and wife via telephone. PICC line remains uncleared for use; waiting for PICC nurse to pull back line. See epic for further details. Guards remain @ bedside. Will continue to monitor.
July 25, 2011, 1321
1254 PICC nurse Lisa @ bedside; PICC pulled back. No CXR ordered. Dr. Newton 54774 notified; PICC ok to use per MD.
July 25, 2011, 1446
1343 Order received for PICC line cleared to use; Dr. Roy (on call intern) notified of pt desat to 80s% when turned on Right side and resolved when laid flat again. No orders @ this time.
1420 Q12 hr labs drawn and sent; results pending. NS tubing changed out to new Right PICC line per protocol. I&O completed. Continue to monitor.
July 25, 2011, 1524
1520 Dr. Roy (on call intern) and Dr. Valley 54789 @ bedside removing Right Femoral Central Line. Dr. Roy notified of lab results; waiting for orders @ this time.

All Notes (continued)

July 25, 2011, 1615
1525 Dr. Roy (on call intern) and Dr. Newton 54774 made aware of drop in H/H from 11/31 to 9/27; will continue to monitor. No active bleeding noted; BP trending downwards but maintaining SBP > 90; urine output > 60-100 cc/hr.
1545 Family @ bedside; updated on pt progress. Guards remain @ bedside. Pt reassessed; no changes from noon assessment. No s/s pain or acute distress. Will continue to monitor.
July 25, 2011, 1753
1600 Bed bath given; skin breakdown noted; see skin sheet. Pt tolerated bath well.
July 25, 2011, 1925
1918 Report given to Ana Frederick, RN. Orders, mar, labs and kardex reviewed.

Electronically Signed by Ashley M Dunnier, RN at 07/25/11 1926

Nurses Notes signed by Ana Marie Frederick, RN at 07/26/11 0407

Author:	Ana Marie Frederick, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/26/11 0407	Note Time:	07/25/11 1918		
Related Notes:	Original Note by: Ana Marie Frederick, RN filed at 07/25/11 2249				

July 25, 2011, 1918
Report received and care assumed. Plan of care reviewed, no changes made at this time.
July 25, 2011, 1956
Unable to elicit cough or gag reflex, primary team aware of neuro status. A-line positional with dampened waveform. Blood return depends on positioning. Circulation intact.
July 25, 2011, 2146
Discussed patient's A-line with Dr. Newton including lack of blood return and dampened waveform. NIBP correlates with cuff pressure, not A-line. Per MD, ok to D/C A-line, if patient's blood pressure progresses to requiring pressor support, will start new A-line.
July 25, 2011, 2249
Patient transferred to Barimaxx bed.
July 26, 2011, 0405
On reassessment, patient is using abdominal muscles on ventilator. Breath sounds clear bilaterally, ABG results improved from previous values, SPO2 remains 100% with PIP between 18-22 and Vte matching set volume. Dr. Bachim at bedside to evaluate. No new orders at this time.

Electronically Signed by Ana Marie Frederick, RN at 07/26/11 0407

Progress Notes signed by Lance S. Terada, MD at 07/26/11 1303

Author:	Lance S. Terada, MD	Service:	Internal Medicine	Author Type:	Attending
Filed:	07/26/11 1303	Note Time:	07/26/11 0729		
Related Notes:	Original Note by: Kevin Ross Davidson, MD filed at 07/26/11 0747				

MICU / Pulmonary Team III Note:

24 hour events: Remains off of or on minimal pressors, tube feedings started, minimal neurologic responses. Had head Ct which shows bilateral low densities in basal ganglia and internal capsules. Guards remain at bedside

Hospital Day:	5	
Drips:	NS @ 50cc/hr	
Lines:	Rt radial A-line	7/22
	Right brachial PICC	7/25
	Foley, rectal, OG	
Antibiotics:	None	

Vent Day:	5
AC:	Vt 600 / 16 / 40% / +5
	7.48 / 31 / 113 / 23 / 100%

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

VS: Tm 37.8 70-90 90-100/55-65 18-22 >99%
I/O: +2.5 | -3.4 | Net: -0.9

General: unresponsive, vented
Chest: Course bilateral breath sounds, symmetric
Cardiac:Distant, unable to appreciate
Abd: Obese, soft, +foley/rectal tube
Neuro: Withdraws from noxious stimuli with limited movement, overbreathes vent but no additional movement.
Ext: Mottling of legs slightly improved from yesterday, no palpable feet pulses. Hands &b feet warm with good cap refill.

Medicines:

• lidocaine injection 1%	10 mL	PRN
• insulin NPH (HUMULIN N;NOVOLIN N) injection 10 Units	10 Units	BID
• insulin regular sliding scale 1-7 Units	1-7 Units	Q6H
• potassium chloride oral solution 10% (20 mEq/15ml)	40 mEq	DAILY
• pantoprazole (PROTONIX) injection DOSE: 40 mg	40 mg	BID
• sodium chloride 0.9% infusion		CONTINUOUS
• hydroxypropyl methylcellulose (ISOPTO TEARS) 0.5 % ophthalmic solution	1 Drop	PRN
• sodium chloride 0.9% infusion		CONTINUOUS
• acetaminophen (TYLENOL) oral solution DOSE: 650 mg	650 mg	Q4HR PRN
• norepinephrine (LEVOPHED) 32 mg in D5W 250 mL	5-200 mcg/min	TITRATE

NA	140	7/26/2011
K	3.2*	7/26/2011
CL	102	7/26/2011
CO2	28	7/26/2011
ANIONGAP	10	7/26/2011
BUN	76*	7/26/2011
CREATININE	3.24*	7/26/2011
GLUCOSE	187	7/26/2011
WBC	5.97	7/26/2011
HGB	9.9*	7/26/2011
HCT	28.6*	7/26/2011
MCV	91.7	7/26/2011
PLT	42*	7/26/2011

7/22	Neuron specific enolase	Pending (was drawn at 12 hours after presentation)

Micro:

7/22	Blood	NG
7/22	Urine	NG
7/22	C Diff	NG
7/22	Fecal WBC	Neg

Problem List:

12. **Unresponsiveness**
13. **Resolving multi-organ dysfunction**
14. **Azotemia**
15. **Acute renal failure, resolving**
16. **Rhabdomyolysis, resolving**
17. **Shock liver, resolving**
18. **Hyperthermia, resolved**
19. **Unwitnessed single seizure**

Assessment & Plan:

58 yo M presenting from prison after report of generalized seizure and marked hyperthermia. The patient was intubated in the ER for unrepsonsiveness and developed acute renal failure, rhabdomyolysis, and circulatory shock which

All Notes (continued)

are now resolving. We are providing supportive care and are hopeful that his neurologic status will improve. He remains on the ventilator with limited neurologic responses.

Neurologic dysfunction:
-Has brainstem function, trigger vent and has some oral movements, can move both arms in limited fashion.
-NSE pending.
-Holding all sedation.
-EEG was neg for subclinical status

Resolving shock with Multiorgan Dysfunction:
-Supportive hemodynamics, TTE shows right sided dysfunction, holding boluses
-Hydrocortisone completeley tapered off
-Supportive care, has been off of pressors for 48 hours

Malignant hyperthermia: Resolved and normothermic.
Rhabdomyolysis: Downtrended to almost normal
Azotemia: Related either to ATN or possibly to GIB. On BID PPI, Cr improving.
ATN: Improving
Prophylaxis: PPI, SCD's
Code Status: DNR

Davidson x4099

Pulmonary Attending
I reviewed and examined Mr McCollum with Dr. Davidson and I concur with the findings and plans recorded. He is still unresponsive/comatose, Tm 37.8. Labs show resolving rhabdo, renal failure, and DIC. Supportive tx for heat stroke. No return in mental status for now. Will get MRI to look for other structural causes. Likely will need early trach.

Lance Terada, MD

Electronically Signed by Lance S. Terada, MD at 07/26/11 1303

Progress Notes signed by A.J. Kunnathusseril, RN, CWOCN at 07/26/11 1335

Author:	A.J. Kunnathusseril, RN, CWOCN	Service:	Wound Care Specialist Author Type: Registered Nurse
Filed:	07/26/11 1335	Note Time:	07/26/11 1322

Allied Health Services Progress Note
Service Area:WOCN WOUND CARE SERVICES.
Name: Larry Gene McCollum
Medical Record Number: 4493765
Admission Date: 7/22/2011 4:00 AM

Note: Patient seen per MD referral,58 yr old WH/M brought in from prison after having had generalized seizures,in multisystem Failure, ARF, shock liver syndrome AMS,intubated vent assisted and unresponsive. Patient is morbidly obese,and is on Bari Maxx bed with Maxx air ETS.. RN noticed a purplish area ,a line DEEP in the buttock fold 4 cms long 0.3 cm wide initially that cracked open athis time like a skin tear. Not a pressure ulcer as this area cannot be touching anything,any surface,the huge buttock mass might have caused surface to surface friction rub and congestion and separating buttock folds to examine the fold also might have caused the tear . This is not a classic pressure related injury, will treat it as a skin tear,a fissured area in the deep fold with Sensicare BID and PRN.
may place on continuous turn mode or may turn him Q 1-2 hrs to sides.Patient is on a DNR Code Status and Is on Tube feed at this time.
Time 1310 hrs to 1340 hrs.
Electronically Signed by:
A.J. KUNNATHUSSERIL, RN, CWOCN # 5450,Pg # 8625.
7/26/2011 1322

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

Electronically Signed by A.J. Kunnathusseril, RN, CWOCN at 07/26/11 1335

Progress Notes signed by Ross Prater at 07/26/11 1422

Author: Ross Prater Service: (none) Author Type: Pastoral Care
Filed: 07/26/11 1422 Note Time: 07/26/11 1422

Spiritual Care Note

Patient's Name: Larry Gene McCollum
MRN: 4493765

Focus of Care: Patient

Faith Community: Baptist
Who Initiated Visit: Chaplain
Date Referral Received:
Time Received:
Length of Contact:
Response Category: Routine

Reason For Visit: Follow Up;Length of Stay

Assessment: (spoke with guard, family in and out, will call us as needed)

Goals: Experience Supportive Presence

Plan of Care:
Follow Up Required?: Yes
A. Follow Up Time Frame: Other (Comment) (24 hour ICU goal)
Refer to:
Or
Discharge Refer to:
Date: Time:

B. Interventions: Sacraments/Ritual;Prayer

Electronically signed by:
ROSS PRATER
7/26/2011 1422

Electronically Signed by Ross Prater at 07/26/11 1422

All Notes

Nurses Notes signed by Ashley M Dunnier, RN at 07/26/11 1924

Author: Ashley M Dunnier, RN Service: (none) Author Type: Registered Nurse
Filed: 07/26/11 1924 Note Time: 07/26/11 0806
Related Notes: Original Note by: Ashley M Dunnier, RN filed at 07/26/11 1812

July 26, 2011, 0806
0720 Report received from Ana Frederick, RN. Orders, mar, labs and kardex reviewed.
0730 Safety check completed. Initial assessment done. Remains off sedation; not opening eyes or following commands. Noted to over breath ventilator. No cough or gag noted with deep in line ETT suction. Withdraws only bilateral upper extremities to nail bed pain only. Right breath sounds clear throughout; left breath sounds diminished throughout. Note to have increased use of abdominal muscles with breathing. Transesophageal temp remains 37.5-37.9; will discuss with Dr. Davidson 54755 and Dr. Jarvie 56327. No s/s pain noted @ this time. Will continue to monitor. See epic for further details. Plan of care reviewed and updates made. Guards remain @ bedside.
July 26, 2011, 1000 Family @ bedside; guards remain @ bedside.
July 26, 2011, 1059
1015 Dr. Davidson 54755 and Dr. Jarvie 56327 @ bedside for rounds.
July 26, 2011, 1619
1130 Pt reassessed. Cough noted when deep in line suction performed through ETT. No other changes noted @ this time from previous assessment. No s/s pain or distress @ this time. Flexiseal rectal tube with small smear BM noted; linens changed. Nepro tube feed tubing changed per protocol. See epic for further details. Will continue to monitor.
1300 Anna K, RN with WOCN @ bedside to assess pt's buttock. Per WOCN RN purple discolored area not pressure ulcer; sensicare and protective ointment applied; see WOCN nurse's notes for details. Will continue to monitor.
1400 I&O completed. Family and guards remain @ bedside.
1405 Labs drawn and sent; results pending.
1530 Lab results shown to Dr. Davidson 54755; orders received.
1600 Pt reassessed with no changes from noon assessment. No s/s pain or distress. Will continue to monitor.
July 26, 2011, 1811
1700 Bed bath given; pt tolerated well. No changes in skin from earlier; protective ointment applied to buttocks.
1800 Dr. Davidson 54755 @ bedside talking with family; guards remain @ bedside.
July 26, 2011, 1924
1910 Report given to Ezinne O., RN. Orders, mar, labs and kardex reviewed and verified.

Electronically Signed by Ashley M Dunnier, RN at 07/26/11 1924

Nurses Notes signed by Ezinne Jessica Onyejiaka, RN at 07/27/11 0719

Author: Ezinne Jessica Onyejiaka, RN Service: (none) Author Type: Registered Nurse
Filed: 07/27/11 0719 Note Time: 07/26/11 1922
Related Notes: Original Note by: Ezinne Jessica Onyejiaka, RN filed at 07/27/11 0650

July 26, 2011, 1922

1915 Report received from Ashley, RN. MAR, Kardex, Labs, Orders reviewed.

July 26, 2011, 2015
2000 Safety check completed. Initial assessment completed. POC reviewed, no changes made. See doc flowsheet. Guards x 2 @ bedside.Pt unresponsive, not responding to pain stimulus, gag and cough reflex absent, corneal reflex noted on assessment, vented on Ac settings, in no acute distress, VSS.

July 27, 2011, 0027
0000 reassessment and safety check done. No changes.

July 27, 2011, 0425
0200 Attempt to take pt to MRI/MRA unsuccessful. MD Davidson notified, said that MRI/MRA is not Stat and can be done during the day.

All Notes (continued)

0400 reassessment and safety check done. No changes. AMLs drawn and sent.

July 27, 2011, 0645
0500 Labs reviewed.
0630 MD Javrie notified of pt's labs.

July 27, 2011, 0718
0700 Report given to David, RN.MAR, Kardex, Labs, Orders reviewed.

Electronically Signed by Ezinne Jessica Onyejiaka, RN at 07/27/11 0719

Progress Notes signed by Elen Petrosyan, RD, LD at 07/27/11 1102

Author: Elen Petrosyan, RD, LD Service: (none) Author Type: Dietitian
Filed: 07/27/11 1102 Note Time: 07/27/11 1054
Related Notes: Original Note by: Elen Petrosyan, RD, LD filed at 07/27/11 1059

Nutrition Support Follow-Up

Pt seen & evaluated per protocol. See Adult Nutrition documentation flowsheet for full details.
Chart & labs reviewed.

Med/Surg Changes/Procedures: off pressors, pending brain MRI/MRA

TF: Nepro @ 40 ml/hr with 1 protein packet TID

IVF: D5-1/2 NS @ 50 ml/hr **UOP:** 3330 ml **BM (RT):** 100 ml **Gastric Residuals/Output:** <0-10 ml>

Assessment:
Pt tolerating current TF regimen, however, doesn't need a restricted formula as pt clearing the elytes. Will change to less restricted and less concentrated formula to help with hyponatremia. Pt with mild hyperglycemia - recommend to adjust sliding scale insulin.

Plan:
1. Change TF to Promote @ 90 ml/hr with 2 protein packets TID
2. Change sliding scale insulin to medium dose q 6 hrs
3. NST following while in ICU

Electronically Signed by:
Elen Petrosyan RD, LD, CNSC
P. 1684

Electronically Signed by Elen Petrosyan, RD, LD at 07/27/11 1102

Progress Notes signed by Lance S. Terada, MD at 07/27/11 1123

Author: Lance S. Terada, MD Service: Internal Medicine Author Type: Attending
Filed: 07/27/11 1123 Note Time: 07/27/11 0715
Related Notes: Original Note by: Jennifer Lynne Jarvie, MD filed at 07/27/11 0734

MICU / Pulmonary Team III Note:

No events overnight. Continues to have improving UOP and requires frequent lyte repletion. No sedation but remains unresponsive. Has remained normothermic for the last several days. Noncontrast MRI/MRA of brain ordered but still not done.

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

Hospital Day: 6
Drips: D5+1/2NS @ 50cc
Lines: Rt radial A-line 7/22
Right brachial PICC 7/25
Foley, rectal, OG
Antibiotics: None
Vent Day: 6

AC: Vt 600 / 16 / 40% / +5

VS: Tc 37 71 93/50 20 96% Vent
I/O: -1.4L

General: unresponsive, vented
Chest: diminished on right, symmetric chest rise, no wheezes, coarse
Cardiac:Distant, unable to appreciate
Abd: Obese, soft, +foley/rectal tube
Neuro: Disconjugate gaze, pupils reactive
Ext: nonpitting edema of bilat UE, warm, good cap refill, no petechiae

Medicines:
Current Inpatient Medications

Medication		Dose	Frequency
• dextrose 5 % + 0.45% NaCl infusion			CONTINUOUS
• potassium chloride oral solution 10% (20 mEq/15ml)		60 mEq	ONCE
• multivitamin oral solution DOSE: 5 mL		5 mL	DAILY
• lidocaine injection 1%		10 mL	PRN
• insulin NPH (HUMULIN N;NOVOLIN N) injection 10 Units		10 Units	BID
• insulin regular sliding scale 1-7 Units		1-7 Units	Q6H
• pantoprazole (PROTONIX) injection DOSE: 40 mg		40 mg	BID
• hydroxypropyl methylcellulose (ISOPTO TEARS) 0.5 % ophthalmic solution Drop	DOSE: 1	1 Drop	PRN
• sodium chloride 0.9% infusion			CONTINUOUS
• acetaminophen (TYLENOL) oral solution DOSE: 650 mg		650 mg	Q4HR PRN
• norepinephrine (LEVOPHED) 32 mg in D5W 250 mL		5-200 mcg/min	TITRATE

Na 147
K 3.2
Cl 113
CO2 29
BUN 63
Creat 1.82
Gluc 143
Ca 7.2
Phos 3.0
Mg 2.1

TP 4.5
Alb 2.2
Dbili 0.6
ALT 200
AST 165
Alk phos 38

INR 1.1/PT 11.0/PTT 21.9
Mon Sep 12, 2011 4:08 PM

All Notes (continued)

WBC 2.8
Hgb 8.3 (downtrending)
Hct 24.6 (downtrending) <-- 26.9 <-- 28.6 <-- 31.3
Plt 46

7/22 Neuron specific enolase Pending (was drawn at 12 hours after presentation)

Micro:
7/22 Blood NG
7/22 Urine NG
7/22 C Diff NG
7/22 Fecal WBC Neg

Problem List:
1. **Unresponsiveness**
2. **Resolving multi-organ dysfunction**
3. **Azotemia**
4. **Acute renal failure**
5. **Rhabdomyolysis**
6. **Anemia**
7. **Shock liver**
8. **Hyperthermia, resolved**
9. **Unwitnessed single seizure**

Assessment & Plan:
58 yo M presenting from prison after report of generalized seizure and marked hyperthermia. The patient was intubated in the ER for unrepsonsiveness and developed acute renal failure, rhabdomyolysis, and circulatory shock which are now resolving. He remains on the ventilator with limited neurologic responses. We continue to provide supportive care and wait to see if he regains neurologic function.

Neurologic dysfunction:
-Has brainstem function, trigger vent and has some oral movements, can move both arms in limited fashion.
-NSE pending.
-Holding all sedation.
-EEG was neg for subclinical status
-Remains unresponsive.
-Brain MRI/MRA ordered

Resolving shock with Multiorgan Dysfunction:
-Supportive hemodynamics, TTE shows right sided dysfunction, holding boluses
-Renal function improving with downtrending creatinine and increased UOP
-Liver enzymes also downtrending. NAC protocol stopped 2 days ago.
-Has been off of all pressors for 4 days.

Malignant hyperthermia: Resolved and normothermic.
-Unknown trigger. Still monitoring temp.

Rhabdomyolysis: Downtrended to almost normal
-Today CK is 4000, peaked at 24000.
-Gentle IVF

Anemia: H&H continue to downtrend. FOBT positive, so likely slow leak from GI source.
-PPI BID
-Trending H&H
-Transfuse if Hbg <7

Azotemia: Related either to ATN or possibly to GIB.

All Notes (continued)

ATN: Improving.
-UOP over 100cc/hr.

Prophylaxis: PPI, SCD's

Code Status: DNR

Jennifer Jarvie
Internal Medicine R1
x6852

Pulmonary Attending
I reviewed and examined Mr McCollum with Dr. Jarvie and I concur with the findings and plans recorded. He remains completely unresponsive. CK, creat improving. SBT good Vt, but will not protect his airway. MRI/MRA pending. Will ask neurology for assistance in prognosticating after studies done. He remains comatose, suspect chances for meaningful recovery are very slim. Will keep family updated.

Lance Terada, MD

Electronically Signed by Lance S. Terada, MD at 07/27/11 1123

Progress Notes signed by Kristi Click at 07/27/11 1615

Author:	Kristi Click	Service:	(none)	Author Type:	Pastoral Care
Filed:	07/27/11 1615	Note Time:	07/27/11 1612		

Spiritual Care Note

Patient's Name: Larry Gene McCollum
MRN: 4493765

Focus of Care: Other: pt's jail guards
Guards told me that the doctor explained pt's grim state and pt needs to have an MRI. The guard said "The family told the doctor they don't want him living like a vegetable so they will probably pull the plug if there is no brain activity." They have mentioned Pastoral Care to the family but the family is not yet interested in visiting with a chaplain. Prayed over the pt.

Faith Community: Baptist
Who Initiated Visit: Chaplain
:
Length of Contact: 10 mins
Response Category: Routine

Reason For Visit: Follow Up;Significant Change in Condition (pt will have an MRI & fam concerned of "vegetative state")

Assessment: Patient/Family Unavailable for Care

Goals: Experience Supportive Presence

Plan of Care:
Follow Up Required?: Yes (24 hour ICU goal)
A. Follow Up Time Frame: Other (Comment) (24 hour ICU goal)

B. Interventions: Prayer

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

Electronically signed by:
Kristi Click
7/27/2011 1612

Electronically Signed by Kristi Click at 07/27/11 1615

Nurses Notes signed by David E. Mendoza, RN at 07/27/11 1850

Author:	David E. Mendoza, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/27/11 1850	Note Time:	07/27/11 0812		
Related Notes:	Original Note by: David E. Mendoza, RN filed at 07/27/11 1251				

July 27, 2011, 0812
0705-Received SBAR report from off-going RN. Assumed care of pt.
0710-Safety and emergency checks per unit protocol completed at this time.
0800-Initial assessment completed at this time. Pt not sedated. Pt unresponsive. Does not follow commands. No spontaneous movement to bilateral upper or lower extremities noted. Sinus rhythm with no ectopy noted per lead II and V. Pt mechanically ventilated via ETT, AC-mode, and tolerating well. Pt with OG-tube, Nepro at goal of 40 ml/hr. Flexiseal with minimal amount of loose diarrhea stool noted in tubing. Foley patent with yellow sediment urine. No acute distress noted at this time. Will continue to monitor and assess pt's status/needs.
July 27, 2011, 1250
1030-MICU MDs at bedside for rounds.
1200-Reassessed per protocol with no acute changes from initial assessment noted. No s/s of acute distress noted. Alverno=0/10. Vital signs remain at baseline trends.
July 27, 2011, 1849
1400-I&Os completed and documented.
1600-Reassessment completed at this time. No acute changes from previous assessments noted. Alverno=0/10. Labs drawn and sent.
1800-Family members visiting at bedside. Vital signs remain at previous baseline trends.

Electronically Signed by David E. Mendoza, RN at 07/27/11 1850

Nurses Notes signed by Ezinne Jessica Onyejiaka, RN at 07/28/11 0740

Author:	Ezinne Jessica Onyejiaka, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	07/28/11 0740	Note Time:	07/27/11 1937		
Related Notes:	Original Note by: Ezinne Jessica Onyejiaka, RN filed at 07/28/11 0740				

July 27, 2011, 1937
1900 Report received from David, RN. MAR, Kardex, Labs, Orders reviewed.
1930 Safety check completed. Initial assessment completed. POC reviewed, no changes made. See doc flowsheet. Guards x 2 @ bedside.Pt unresponsive, not responding to pain stimulus, reflexes present and noted on assessment, vented on Ac settings, in no acute distress, VSS, pt febrile temp 37.7, MD Bachim notified, pt given tylenol through NGT and ice packs placed to under arms. Wife and daughter @ bedside.

July 28, 2011, 0023
0000 reassessment and safety check completed. No change from previous. Pt VSS, in no acute distress. Insulin given, see MAR

July 28, 2011, 0448
0400 reassessment and safety check completed. No change from previous. Pt VSS, in no acute distress.
0415 AMLs sent.

July 28, 2011, 0735
0450 Pt going to MRI. RT @ bedside and Gaurds x 2.

All Notes (continued)

0530 MRI in progress. Pt given 2mg of Ativan IVP. AMLs reviewed.
0630 MRI done.
0700 Pt back from MRI, VS changed from baseline, pt hypertensive with SBP 160's and HR in the 110's. Pt also not sychronise with the mechanical vent. MD Davidson notified.
0715 Report given to Tina, RN.MAR, Kardex, Labs, Orders reviewed.

Electronically Signed by Ezinne Jessica Onyejiaka, RN at 07/28/11 0740

Progress Notes signed by Zhen Yan, MD at 07/28/11 1146

Author:	Zhen Yan, MD	Service:	Blood Bank/Transfusion Management	Author Type:	PGY 1
Filed:	07/28/11 1146	Note Time:	07/28/11 1142		

Transfusion Medicine Resident Notes:

We got a request for two units of platelets. The patient's most recent PLT count 75, with bilateral low densities in basal ganglia, and internal capsule. No anti-platelets medicine was used in the last five days. At this time, only one unit PLTs is indicated. Please cancel the order and re-order one unit of PLT.

Please refer to the transfusion Medicine Web site for the guideline.

http://intranet.pmh.org/Transfusion/plateletsguide.asp

Zhen Yan, MD, PhD
Transfusion Medicine Resident R1

Electronically Signed by Zhen Yan, MD at 07/28/11 1146

Progress Notes signed by Gagandeep Singh, MS III at 07/28/11 1357

Author:	Gagandeep Singh, MS III	Service:	(none)	Author Type:	MS III
Filed:	07/28/11 1357	Note Time:	07/28/11 0915		
Related Notes:	Cosigned by: Hai Chen, MD,PHD filed at 07/28/11 1636				
	Original Note by: Gagandeep Singh, MS III filed at 07/28/11 1245				

Admit Date: 7/22/2011 LOS: 6 days
Subjective:
Reason for consult: Neurological Prognosis

Mr. McCollum is 58 y/o morbidly obese caucasian man with PMH of HTN, DM, Arthritis, Major Depression who presented from prison after a witnessed seizure while in common area.

Per MICU resident(Dr. Davidson) and Prison Guards present in the room: There are no details to the patient's clinical course leading up to his seizure and he has no known history of epilepsy. He reportedly has been in this prison for only 4 days and was recently at another jail facility. His jail is a non-air conditioned facility. His seizure occurred ~0300 hours and he was brought to Parkland by EMS. His temperature was noted to be 104° F when he left the facility and his temperature rose to 109° F by the time he got to ER. In the ER he was initially hypertensive ~200/150, he had no gag, cough, or grimace and was completely unresponsive. He was then intubated and given etomidate and succinylcholine. His blood pressure decompensated and he was started on dopamine and levophed(Norepinephrine) at high levels. Attempts were made to cool him with ice water NG lavage and packing his groin and axillae with ice packs.

EEG done the same day showed generalized non-reactive slowing with electrodecrements indictive of severe, nonspecific and nonlocalizing encephalopathy . No Jerky or twitching movements have been noticed and he has been unresponsive during the entire time of his admission.

This morning Pt. was intubated and not on sedation. Patient breathing looked labored with exaggerated head movement.

All Notes (continued)

Pt was unresponsive to voice and noxious stimuli (Supraorbital nerve compression, Sternal rub, Nail bed compression). I did not notice any twitching or jerky movements.

Review of Systems: Unable to obtain

(Medications, Allergies, PMH, PSH, FHx and SHx are per patient chart)

Medications
- HCTZ (25mg) daily
- Previously on 0.1 clonidine

Current Inpatient Medications

Medication	Dose	Frequency
• acetaZOLAMIDE (DIAMOX) injection 500 mg	500 mg	Q12H
• D5W IV Solution		CONTINUOUS
• sterile water injection for medication reconstitution 5 mL	5 mL	BID (DIURETIC)
• insulin regular sliding scale injection 2-14 Units	2-14 Units	Q6H
• insulin NPH (HUMULIN N;NOVOLIN N) injection 5 Units	5 Units	BID
• acetaminophen (TYLENOL) oral solution DOSE: 650 mg	650 mg	Q4HR PRN
• multivitamin oral solution DOSE: 5 mL	5 mL	DAILY
• lidocaine injection 1%	10 mL	PRN
• pantoprazole (PROTONIX) injection DOSE: 40 mg	40 mg	BID
• hydroxypropyl methylcellulose (ISOPTO TEARS) 0.5 % ophthalmic solution DOSE: 1 Drop	1 Drop	PRN
• sodium chloride 0.9% infusion		CONTINUOUS
• norepinephrine (LEVOPHED) 32 mg in D5W 250 mL	5-200 mcg/min	TITRATE

Allergies : Unknown

Past Medical History
- HTN
- Major Depression
- DM
- Arthritis

Past Surgical History
- None

Family History
- Unspecified Cancer
- DM
- HTN
- Heart disease

Social History
- Incarcerated
- No know Hx of EtOH or recreational drug use

Objective:

BP 150/92 | Pulse 135 | Temp 38.3 °C (100.9 °F) | Resp 24 | Ht 6' 1" | Wt 167 kg (368 lb 2.7 oz) | BMI 48.57 kg/m2 | SpO2 92%

Physical Exam

GENERAL: Intubated obese caucasian man with labored breathing (Overbreathing the ventilator), No spontaneous movements, unresponsive to voice and painful stimuli
HEAD: NCAT,
CARDIOVASCULAR: Unable to auscultate heart sounds
RESPIRATORY: CTAB
EXTREMITIES: No edema
SKIN: No rashes

All Notes (continued)

NEUROLOGICAL EXAM:
Mental Status: Unresponsive to vocal, noxious stimuli
Cranial Nerves:
CN II and CN III: Pupillary reflex intact in both eyes
CN III, IV, VI: Eyes midline- no movement, No nystagmus
CN V and VII: Corneal Reflex intact
CN IX and CN X: No gag reflex
Motor: No muscle atrophy. No movements in any limb.
Reflexes: Could not elicit any DTR's
Sensation: No response to noxious stimulus
Co-ordination: Deferred
Gait: Deferred

Glasgow Coma score: 3 (Eye-1, Motor-1, Verbal-1)

Pertinent Labs:

Lab Results

Component	Value	Date
NA	149*	7/28/2011
K	3.8	7/28/2011
CL	113*	7/28/2011
CO2	32*	7/28/2011
ANIONGAP	4*	7/28/2011
BUN	47*	7/28/2011
CREATININE	1.44*	7/28/2011
GLUCOSE	151	7/28/2011

Lab Results

Component	Value	Date
AST	340*	7/28/2011
ALT	172*	7/28/2011
ALKPHOS	34*	7/28/2011
BILITOTAL	0.6	7/28/2011
BILIDIRECT	0.3	7/24/2011
AMYLASE	65	7/23/2011
LIPASE	114*	7/23/2011
ALB	2.5*	7/28/2011

Lab Results

Component	Value	Date
PHART	7.50*	7/28/2011
PCO2ART	35	7/28/2011
PO2ART	125*	7/28/2011
HCO3ART	27*	7/28/2011
BEART	3.8*	7/28/2011
O2SATART	100*	7/28/2011

Lab Results

Component	Value	Date
WBC	2.62*	7/28/2011
HGB	8.8*	7/28/2011
HCT	26.4*	7/28/2011
MCV	95.3	7/28/2011
PLT	75*	7/28/2011
LYMPHSABS	0.44*	7/28/2011
MONOSABS	0.22	7/28/2011
EOSABS	0.01	7/28/2011
BASOSABS	0.00	7/28/2011

Lab Results

Component	Value	Date
GLUCOSE	151	7/28/2011

Lab Results

Component	Value	Date
PROTIME	10.9	7/28/2011
INR	1.0	7/28/2011
PTT	21.4*	7/28/2011
HGB	8.8*	7/28/2011

All Notes (continued)

HCT	26.4*	7/28/2011
PLT	75*	7/28/2011

CK (Total): 11783
HBV: Negative
HCV: Negative
HIV: Negative
Blood Culture: Negative
C. Difficile: Negative
Neuron Specific Enolase: 43 (Nl:<15)
Occult Blood Fecal Guaiac: Positive
Toxicology: Negative
UA: Ketones(15), Protein(30), WBC(7)
IMAGING:
CT Brain(07/22/2011): No Intracranial Abnormalities
CT Brain(07/23/2011): Interval development of bilateral low densities within the basal ganglia and internal capsules, concerning for hypoxic ischemic injury.
MRI Brain-MRA Head(07/28/2011):
- Restricted diffusion involving the cortices diffusely, bilateral basal ganglia, and hippocampi, compatible with diffuse anoxic brain injury.
- Abnormal signal and enlargement of both cerebellar hemispheres, resulting in mass effect on the fourth ventricle and acute hydrocephalus with transependymal flow of CSF. Questionable restricted diffusion also involves the cerebellar hemispheres

Assessment and Plan:
Prognosis: Mr. McCollum's CT and MRI clearly establish diffuse anoxic brain injury involving bilateral basal ganglia and hippocampi. Brain MRI done this morning also indicates development of Acute hydrocephalus with abnormal enlargement of both cerebellar hemispheres possibly due to edema 2/2 to possible anoxic injury in cerebellum(obstructive hydrocephalus). His condition is further confounded by acute metabolic derangements (Renal failure, liver failure, shock). His motor responses are absent including eye opening. The only indication of his intact cranial nerve activity is his intact pupillary and corneal reflex. Spontaneous breathing indicates intact Brain stem function.

His serum Neuron Specific Enolase level of 43 (>33) is very specific although not very sensitive marker for poor prognosis.Based on study done on patients presenting with nontraumatic coma (Levy DE, Bates D, Caronna JJ, Cartlidge NE, Knill-Jones RP, Lapinski RH, Singer BH, Shaw DA, Plum F. Prognosis in nontraumatic coma. Ann Intern Med. 1981 Mar;94(3):293–301.) : In patients at 7 days of onset of their nontraumatic coma with no eye opening, 92%(24/26) of patients had no recovery or were in vegetative state after 1 year.

Plan:
- Recommend NSG consultation for possible ventricular shunt/ EVD placement to help resolve acute hydrocephalus
- Recommend family consultation given the invasive nature of NSG procedures
- Will follow patient to access any changes in neurological exam that might affect his prognosis.

Electronically Signed by:
GAGANDEEP SINGH, MS III

Electronically Signed by Gagandeep Singh, MS III at 07/28/11 1357

Consults signed by Hai Chen, MD,PHD at 07/28/11 1401

Author: Hai Chen, MD,PHD Service: Neurology Author Type: PGY 2
Filed: 07/28/11 1401 Note Time: 07/28/11 0821
Related Notes: Cosigned by: Mike A. Singer, MD filed at 08/08/11 1513

Consult Orders:
1. Consult Neurology Service [118664904] ordered by Kevin Ross Davidson, MD at 07/28/11 0755

Admission: 7/22/2011 4:00 AM

All Notes (continued)

CC:
Admit after heat shock
Consult for prognosis

HPI:

58 year male presented from prison was sent to Parkland after a pass out episode?. He was noted to be febrile to 43° and with decreased responsiveness and was sent to ER. He become unresponsive and was intubated in ER. He also need pressor for BP mainatance and was cooled with NG lavarge and ice packs.
His temperature is gardually improved and he gradually developped multiple organ dysfunction including cardiac renal, liver injury and rhabdomyolysis. He got supportive treatment and currently renal function and liver enzyme, CK all improved. Off pressor for 5 days. However Pt continue to be unresponsive.
He only got one dose of sedation at intubation in ER, and 4mg ativan 4 h ago (5am today) before MRI study. Per primary team, pt never overbreath ventilator or present with cough at suction.
However pt is not responsive and consult for prognosis.

Recent studies
CT (7/23)
1. Interval development of bilateral low densities within the basal ganglia and internal capsules, concerning for hypoxic ischemic injury. Further evaluation with MR of the brain is recommended as clinically indicated. Dr Brent Bachim was notified directly by telephone of these findings at approximately 1925 on 23 July 2011.

MRI (7/28)
1. Restricted diffusion involving the cortices diffusely, bilateral basal ganglia, and hippocampi, compatible with diffuse anoxic brain injury.
2. Abnormal signal and enlargement of both cerebellar hemispheres, resulting in mass effect on the fourth ventricle and acute hydrocephalus with transependymal flow of CSF. Questionable restricted diffusion also involves the cerebellar hemispheres.

EEG
No-epileptiform

History

Social History

• Marital Status:	Single
Spouse Name:	N/A
Number of Children:	N/A
• Years of Education:	N/A

Occupational History
- Not on file.

Social History Main Topics

• Smoking status:	Never Smoker
• Smokeless tobacco:	Never Used
• Alcohol Use:	3.0 oz/week
6 Cans of beer per week	
last alcohol use ~2yrs ago	
• Drug Use:	No
• Sexually Active:	Yes -- Female partner(s)
Birth Control/ Protection:	None

Other Topics	Concern

- Not on file

Social History Narrative
- No narrative on file

Past Medical History

Diagnosis	Date

All Notes (continued)

- Hypertension

Family History

Problem	Relation	Age of Onset
• Diabetes	Father	
• Psychiatry *alzheimers*	Mother	
• Diabetes	Brother	
• Cancer *prostate CA*	Brother	
• Cancer *pancreatic CA*	Brother	

No family Hx of

Past Surgical History

Procedure	Date
• None (no surgical history)	

ROS:
Not able to get from the patient. (+) fever

Physical Exam
BP 150/92 | Pulse 135 | Temp 38.3 °C (100.9 °F) | Resp 23 | Ht 6' 1" | Wt 167 kg (368 lb 2.7 oz) | BMI 48.57 kg/m2 | SpO2 93%
General: not responsive on ventilator
Neck: neck, no bruit
Neurological:
General: non-responsive,.
CRANIAL NERVES:
Corneal reflex (+) bilaterally, bilaterally pupil reflex to light sluggish. Gag reflex (-), No resposve to noxisous stimuli including stronge chest rub, pressure on all extremities.

MEDICATIONS:
Outpatient medication
No current facility-administered medications on file prior to encounter.

No current outpatient prescriptions on file prior to encounter.

Current inpatient meds
Current Inpatient Medications

Medication	Dose	Frequency
• acetaZOLAMIDE (DIAMOX) injection 500 mg	500 mg	Q12H
• D5W IV Solution		CONTINUOUS
• sterile water injection for medication reconstitution 5 mL	5 mL	BID (DIURETIC)
• insulin regular sliding scale injection 2-14 Units	2-14 Units	Q6H
• insulin NPH (HUMULIN N;NOVOLIN N) injection 5 Units	5 Units	BID
• acetaminophen (TYLENOL) oral solution DOSE: 650 mg	650 mg	Q4HR PRN
• multivitamin oral solution DOSE: 5 mL	5 mL	DAILY

All Notes (continued)

• lidocaine injection 1%		10 mL	PRN
• pantoprazole (PROTONIX) injection	DOSE: 40 mg	40 mg	BID
• hydroxypropyl methylcellulose (ISOPTO TEARS) 0.5 % ophthalmic solution	DOSE: 1 Drop	1 Drop	PRN
• sodium chloride 0.9% infusion			CONTINUOUS
• norepinephrine (LEVOPHED) 32 mg in D5W 250 mL		5-200 mcg/min	TITRATE

LABS:

Lab Results

Component	Value	Date
WBC	2.62*	7/28/2011
HGB	8.8*	7/28/2011
HCT	26.4*	7/28/2011
MCV	95.3	7/28/2011
PLT	75*	7/28/2011

Lab Results

Component	Value	Date
NA	149*	7/28/2011
K	3.8	7/28/2011
CL	113*	7/28/2011
CO2	32*	7/28/2011
ANIONGAP	4*	7/28/2011
BUN	47*	7/28/2011
CREATININE	1.44*	7/28/2011
GLUCOSE	151	7/28/2011

A/P:

Larry Gene McCollum is a 58 year old male was admitted after shock shock. presnet with multiple organ dysfunction and are improving. However continue to be unresponsive. CT

1. Neurological prognosis.
- Pt is not able to opn eyes to painful stimuli on day 6. Per Levy Criteria for non-traumatic comaguideline (Day 7 after the insult), best one year recovery will be: 92% no recovery, continue veg state; 8% severe disabled; 0% moderate disabled or good recovery.
- Please note, renal failure, liver failure, other significant metabolic disturbance or hemodynamic instability (all improved) can confound the clinical findings.
- Though not in the guideline, CT and MRI both revealed diffuse anoxic brain injury (restricted diffusion involving the cortices diffusely, bilateral basal ganglia, and hippocampi) which suggest severe brain injury.

Chen Hai M.D., Ph.D.

Electronically Signed by Hai Chen, MD,PHD at 07/28/11 1401

Progress Notes signed by Ross Prater at 07/28/11 1523

Author: Ross Prater Service: (none) Author Type: Pastoral Care
Filed: 07/28/11 1523 Note Time: 07/28/11 1523

Spiritual Care Note

Patient's Name: Larry Gene McCollum

Focus of Care: Patient

Faith Community: Baptist
Who Initiated Visit: Chaplain
Date Referral Received:
Time Received:
Length of Contact:
Response Category: Routine

Reason For Visit: Follow Up;Length of Stay

Assessment: Patient/Family Unavailable for Care

Goals: Experience Supportive Presence

Plan of Care:
Follow Up Required?: Yes (24 hour ICU goal)
A. Follow Up Time Frame: Other (Comment) (24 hour ICU goal)
Refer to:
Or
Discharge Refer to:
Date: Time:

B. Interventions: Sacraments/Ritual;Prayer

Electronically signed by:
ROSS PRATER
7/28/2011 1523

Electronically Signed by Ross Prater at 07/28/11 1523

Progress Notes signed by Kevin Ross Davidson, MD at 07/28/11 1538

Author: Kevin Ross Davidson, MD Service: Pulmonary Diseases Author Type: PGY 3
Filed: 07/28/11 1538 Note Time: 07/28/11 1531

Brief MICU Note

I have spoken with the family including Mr. McCollum's wife, daughter, and sons. They understand the patient's critical condition and extensive neurologic injury. We have discussed the results of the MRI including his diffuse anoxic brain injury and compressive hydrocephalus. After discussion of treatment options, the wife and family have decided to pursue comfort measures only and to withdraw care. This decision is in keeping with the patient's previous expressed beliefs to not want life support or live in a manner where he did not have his full faculties. We are awaiting additional family members to arrive at bedside and join the wife, son, and daughters who are here. The police officers guarding the patient have been notified as well.

Davidson x4099

Electronically Signed by Kevin Ross Davidson, MD at 07/28/11 1538

Progress Notes signed by Lance S. Terada, MD at 07/28/11 1541

All Notes (continued)

Progress Notes signed by Lance S. Terada, MD at 07/28/11 1541 (continued)

Author: Lance S. Terada, MD Service: Internal Medicine Author Type: Attending
Filed: 07/28/11 1541 Note Time: 07/28/11 1140
Related Notes: Original Note by: Kevin Ross Davidson, MD filed at 07/28/11 1205

MICU / Pulmonary Team III Note:

Had MRI/MRA done this morning showing extensive global strokes as well as acute compressive hydrocephalus. Neurosurgery and neurology both consulted. Patient less responsive on exam. Remains hypernatremic.

Hospital Day: 7
Drips: None
Lines: Rt radial A-line 7/22
Right brachial PICC 7/25
Foley, rectal, OG
Antibiotics: None

Vent Day: 7
AC: Vt 500 / 16 / 40% / +5
VS: Tc 38.2 70-115 95-160/50-90 18-22 71 93/50 20 96% Vent
I/O: +2.9 | -3.8 | -0.9

General: unresponsive, vented
Chest: diminished on right, symmetric chest rise, no wheezes, coarse
Cardiac:Distant, unable to appreciate
Abd: Obese, soft, +foley/rectal tube
Neuro: Pupils no longer reactive, no longer withdrawing from pain.
Ext: Nonpitting edema of bilat UE, warm, good cap refill, no petechiae

Medicines:

• sterile water injection for medication reconstitution 5 mL	5 mL	BID (DIURETIC)
• ranitidine (ZANTAC) syrup DOSE: 150 mg	150 mg	BID
• insulin regular sliding scale injection 2-14 Units	2-14 Units	Q6H
• insulin NPH (HUMULIN N;NOVOLIN N) injection 5 Units	5 Units	BID
• acetaminophen (TYLENOL) oral solution DOSE: 650 mg	650 mg	Q4HR PRN
• multivitamin oral solution DOSE: 5 mL	5 mL	DAILY
• lidocaine injection 1%	10 mL	PRN
• hydroxypropyl methylcellulose (ISOPTO TEARS) 0.5 % ophthalmic solution	1 Drop	PRN
• sodium chloride 0.9% infusion		CONTINUOUS

Na	149
K	3.8
Cl	113
CO2	32
BUN	47
Cr	1.44 (1.62)

WBC	2.62
Hgb	8.8
Hct	26.4
Plat	75

AST	340
ALT	172

7/22 Neuron specific enolase Pending

Micro: 7/22 Blood NG
7/22 Urine NG

All Notes (continued)

7/22 C Diff NG
7/22 Fecal WBC Neg

Problem List:

10. Unresponsiveness
11. Resolving multi-organ dysfunction
12. Azotemia
13. Acute renal failure
14. Rhabdomyolysis
15. Anemia
16. Shock liver
17. Hyperthermia, resolved
18. Unwitnessed single seizure

Assessment & Plan:

58 yo M presenting from prison after report of generalized seizure and marked hyperthermia. The patient was intubated in the ER for unrepsonsiveness and developed acute renal failure, rhabdomyolysis, and circulatory shock which are now nearly resolved. Overnight he had MRI/MRA which shows extensive bilateral anoxic brain injury as well as acute compressive hydrocephalus. Family is en route to the hospital to discuss MR findings and decide upon ventriculostomy.

Extensive global CVA:

-Neurosurg consulted for possible ventriculostomy given compressive hydrocephalus
-Neurology consulted as well given findings.
-Decreased neuro exam today, no longer responsive pupils
-Maintaining hypernatremia, head of bed elevated, considering for ventriculostomy
-All sedation remains held
-NSE pending.
-EEG was neg for subclinical status
-Remains unresponsive.

Resolving shock with Multiorgan Dysfunction:

-Supportive hemodynamics, TTE shows right sided dysfunction, holding boluses
-Renal function improving with downtrending creatinine and increased UOP
-Liver enzymes also downtrending. NAC protocol stopped 2 days ago.

Rhabdomyolysis: Rebounded slightly today along with AST. Creatinine remains downtrending
Anemia: H&H stable. Remains on acid suppression
ATN: Improving. Cr downtrending
Prophylaxis: PPI, SCD's
Code Status: DNR

Davidson x4099

Pulmonary Attending
I reviewed and examined Mr McCollum with Dr. Davidson and I concur with the findings and plans recorded. His pupils are unreactive. CT shows diffuse brain edema and obstructive hydrocephalus from 4th ventricle compression. This was not present on first 2 scans. Prognosis remains very poor even with ventriculostomy. Family to decide about withdrawal of care. Not extubation candidate unless we opt for comfort care.

Lance Terada, MD

Electronically Signed by Lance S. Terada, MD at 07/28/11 1541

Progress Notes signed by Hai Chen, MD,PHD at 07/28/11 1543

Author:	Hai Chen, MD,PHD	Service:	Neurology	Author Type:	PGY 2
Filed:	07/28/11 1543	Note Time:	07/28/11 1542		

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

Discussed with primary team Dr. Davidson. Family wishes to withdraw care. Consult cancelled.
Call with any additional Qs.

Electronically Signed by Hai Chen, MD,PHD at 07/28/11 1543

Progress Notes signed by Ana Marie Wilson at 07/28/11 1811

Author:	Ana Marie Wilson	Service:	(none)	Author Type:	Pastoral Care
Filed:	07/28/11 1811	Note Time:	07/28/11 1809		

Spiritual Care Note

Patient's Name: Larry Gene McCollum
MRN: 4493765

Focus of Care: Family Member(s)

Helped other chaplain during withdraw of support and answering questions for the family regarding autopsy and jail involvement/payment from here. Officer Sessions stated the family would only be responsible for the funeral home/burial expenses.

Faith Community: Baptist
Who Initiated Visit: Chaplain

Length of Contact:35 min
Response Category: Urgent

Reason For Visit: End of Life Care

Assessment: Religious/Spiritual Support

Goals: Experience Supportive Presence

Plan of Care:
Follow Up Required?: Yes
A. Follow Up Time Frame: Other (Comment) (through the dying process)

B. Interventions: Supportive Dialogue/Empathic Listening;Grief Facilitation/Education

Electronically signed by:
Ana Marie Wilson
7/28/2011 1809

Electronically Signed by Ana Marie Wilson at 07/28/11 1811

Progress Notes signed by Kevin Ross Davidson, MD at 07/28/11 1908

Author:	Kevin Ross Davidson, MD	Service:	Pulmonary Diseases	Author Type:	PGY 3
Filed:	07/28/11 1908	Note Time:	07/28/11 1824		
Related Notes:	Original Note by: Kevin Ross Davidson, MD filed at 07/28/11 1825				

Brief MICU Note:

Patient extubated in accordance with family and patient's own prior wishes. He is on morphine GTT titrated to air hunger

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

and signs of any suffering. Transfer orders are in place for a private room outside of the MICU.

Davidson x4099

Electronically Signed by Kevin Ross Davidson, MD at 07/28/11 1908

Nurses Notes signed by Tina Marie Harris, RN at 07/28/11 1924

Author: Tina Marie Harris, RN Service: (none) Author Type: Registered Nurse
Filed: 07/28/11 1924 Note Time: 07/28/11 0911
Related Notes: Original Note by: Tina Marie Harris, RN filed at 07/28/11 1810

July 28, 2011, 0911
0800 Is unresponsive. See flowsheet for complete assessment. POC reviewed. No changes made. Is unresponsive. No family at bedside. No nonverbal indicators of pain.
July 28, 2011, 1224
1200 No changes in assessment. No nonverbal indicators of pain.
July 28, 2011, 1653
1500 Family in conference room with Dr. Davidson discussing plan of care.
1600 Family wishes to withdraw care when other family members arrive. Pupils are nonreactive. No other changes in assessment. No nonverbal indicators of pain.
July 28, 2011, 1710
1708 Morphine 4 mg IV given. PCA morphine gtt started at 5 mg/h. Family at bedside.
July 28, 2011, 1730
1724 ETT pulled (care withdrawn) by Dr. Davidson. Family at bedside.
July 28, 2011, 1809
1800 Okay per Dr. Davidson to not get BP. Family at bedside praying. Is comfort care only. Transfer to floor orders written.
July 28, 2011, 1923
1920 VS stable. Report given to oncoming RN.

Electronically Signed by Tina Marie Harris, RN at 07/28/11 1924

Progress Notes signed by Charles Taylor Owens, MD at 07/28/11 2356

Author: Charles Taylor Owens, MD Service: Internal Medicine Author Type: PGY 3
Filed: 07/28/11 2356 Note Time: 07/28/11 2356

Death Note:

This entry is clinical documentation by Charles Taylor Owens, MD regarding Patient Larry Gene McCollum, 4493765. Mr. McCollum was examined by me and has no detectable pulse, blood pressure, respirations, gag and corneal reflexes are absent and is deceased. The time of death was recorded at 11:35 pm on 7/28/2011

The time of this examination is 2356 on 7/28/2011.

The Family has/have been notified.

Electronically Signed by:
Charles Taylor Owens, MD

Electronically Signed by Charles Taylor Owens, MD at 07/28/11 2356

All Notes

Nurses Notes signed by Nichole Joelle Zahand, RN at 07/29/11 0239

Author: Nichole Joelle Zahand, RN Service: (none) Author Type: Registered Nurse
Filed: 07/29/11 0239 Note Time: 07/28/11 2040
Related Notes: Original Note by: Nichole Joelle Zahand, RN filed at 07/29/11 0053

July 28, 2011, 2040
1915 - Report received from offgoing RN. Mar, kardex, labs, and orders reviewed. Care assumed at this time.
2000 - Assessment and safety check completed at this time. See EMR for all assessment details and VS. Pt on morphine gtt, see eMAR for details. Pt comfort care only. Per MD Davidson, will assess qshift and VS q4hr. Family at bedside, questions answered. Patient awaiting transfer to private room.

July 28, 2011, 2312
Family remains at bedside, pt's breathing slowing, slightly more shallow than previously. Also noting some ST depression on EKG, still sinus tachycardia on the monitor. MD Ramirez aware.

July 28, 2011, 2328
Pt brady'd down to asystole, MD Ramirez and MD Owens notified, to bedside now. Family at bedside. Chaplain paged

July 29, 2011, 0050
2335 - Death exam performed by MD Ramirez, TOD called by MD Owens. Family at bedside. Morphine gtt stopped.
2350 - Chaplain visiting with family, awaiting arrival of OIG officer and prison Major to clear the body for release.
0045 - Prison major, captain, and OIG officer at bedside to complete required reports.

July 29, 2011, 0238
0130 - DCME notified, case accepted. Family aware, chaplain notified. Body released to RN for post-mortem care.
0220 - body transported to morgue.

Electronically Signed by Nichole Joelle Zahand, RN at 07/29/11 0239

Progress Notes signed by Crystal L. Horne at 07/29/11 0330

Author: Crystal L. Horne Service: (none) Author Type: Pastoral Care
Filed: 07/29/11 0330 Note Time: 07/29/11 0329

Spiritual Care Note

Patient's Name: Larry Gene McCollum
MRN: 4493765

Focus of Care: Family Member(s)

Faith Community: Baptist
Who Initiated Visit: Chaplain
Date Referral Received:
Time Received:
Length of Contact:
Response Category: Urgent

Reason For Visit: End of Life Care

Assessment: Religious/Spiritual Support

Goals: Experience Supportive Presence

Plan of Care:
Follow Up Required?: Yes

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

A. Follow Up Time Frame: Other (Comment) (through the dying process)
Refer to:
Or
Discharge Refer to:
Date: Time:

B. Interventions: Supportive Dialogue/Empathic Listening;Grief Facilitation/Education

Electronically signed by:
CRYSTAL L. HORNE
7/29/2011 0330

Electronically Signed by Crystal L. Horne at 07/29/11 0330

Consults signed by Kim Luann Rickert, MD at 07/29/11 0631

Author: Kim Luann Rickert, MD Service: Surgery, Neurological Author Type: Attending
Filed: 07/29/11 0631 Note Time: 07/28/11 1125
Related Notes: Related Note by: Benjamin Paul Boudreaux, MD filed at 07/28/11 1246

Original Note by: Benjamin Paul Boudreaux, MD filed at 07/28/11 1246

Consult Orders:
1. Consult Neurosurgery Service [118664907] ordered by Kevin Ross Davidson, MD at 07/28/11 1049

Neurosurgery Progress Note

Patient Active Hospital Problem List:
Malignant hyperthemia (7/22/2011)
Shock (7/22/2011)
Acute renal failure (7/22/2011)
Rhabdomyolysis (7/22/2011)

HD 6

Subjective: 58 year old male with history of hypertension admitted from jail with history of heat exhaustion and seizure. He was brought to PMH with temp 43 C, hypertensive with SBP near 200 and unresponsive. He was intubated and cooled with transfer to MICU service. Acutely he had AKI, shock liver and rhabdomyolysis. EEG performed to rule out subclinical status. Over the last several days the patient has had only minimal responsiveness to painful stimulus. MR was performed, neurosurgery consulted for evaluation of hydrocephalus on MR scan.

ROS - unable to obtain

PMhx -
HTN
Depression
DM
Arthritis

Sochx -
Incarcerated, no history of drug or ETOH abuse

Meds:
HCTZ 25mg daily
Clonodine prn

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

EEG (spoke with EEG front desk)- generalized nonreactive slowing. Nonspecific nonlocalizing encephalopathy. No seizures or status epilepticus seen.

Objective:
Temp (24hrs), Avg:37.7 °C (99.8 °F), Min:37 °C (98.6 °F), Max:38.3 °C (100.9 °F)
Heart Rate Avg: 84.8 bpm Min: 65 bpm Max: 116 bpm
Systolic (24hrs), Avg:118 mmHg, Min:100 mmHg, Max:150 mmHg
Diastolic (24hrs), Avg:66 mmHg, Min:54 mmHg, Max:92 mmHg
O2 Sats: SpO2 Avg: 95.6 % Min: 92 % Max: 100 %
ICPs: No Data Recorded
CPP: No Data Recorded

Intake/Output Summary (Last 24 hours) at 07/28/11 1150
Last data filed at 07/28/11 1100

	Gross per 24 hour
Intake	2923 ml
Output	3910 ml
Net	-987 ml

Intubated, off sedation
No eye opening
Pupils 2mm and reactive
+ corneal
No cough or gag
+ overbreathing
No movement to central painful stimulus

Lab Results

Component	Value	Date/Time
NA	149*	7/28/11 03:30 AM
K	3.8	7/28/11 03:30 AM
CL	113*	7/28/11 03:30 AM
CO2	32*	7/28/11 03:30 AM
BUN	47*	7/28/11 03:30 AM
CREATININE	1.44*	7/28/11 03:30 AM
GLUCOSE	151	7/28/11 03:30 AM
CALCIUM	7.0*	7/28/11 03:30 AM
MAG	1.8	7/28/11 03:30 AM
PHOS	2.3*	7/28/11 03:30 AM

Lab Results

Component	Value	Date/Time
WBC	2.62*	7/28/11 03:30 AM
HGB	8.8*	7/28/11 03:30 AM
HCT	26.4*	7/28/11 03:30 AM
PLT	75*	7/28/11 03:30 AM

Lab Results

Component	Value	Date/Time
PROTIME	10.9	7/28/11 03:30 AM
PTT	21.4*	7/28/11 03:30 AM
INR	1.0	7/28/11 03:30 AM

Lab Results

Component	Value	Date

Patient Name: McCollum, Larry Gene (MRN: 4493765)

All Notes (continued)

PHART	7.50*	7/28/2011
PCO2ART	35	7/28/2011
PO2ART	125*	7/28/2011
HCO3ART	27*	7/28/2011
BEART	3.8*	7/28/2011
O2SATART	100*	7/28/2011

Imaging MR reviewed. Acute infarct in bilateral cerebellum, basal ganglia and cerebral cortex. Effacement of 4th ventricle due to posterior fossa strokes with hydrocephalus.

Assessment: 58 year old male with anoxic brain injury and poor neurologic exam. MR overnight demonstrates hydrocephalus

Plan:
1. I spoke with the family over the phone about the patient's current neurologic status. His neurologic exam has been poor without improvement over several days. He has diffuse strokes throughout his brain likely secondary to anoxic brain injury. The likelyhood of a functional outcome is very low. Treatment of the patient's hydrocephalus would be bedside ventriculostomy placement. This would have to be coupled with platelet transfusion given his low platelet count. The family understands the severity of his underlying brain injury. I explained that there might be some neurologic improvement after ventriculostomy placement but meaningful recovery was unlikely. At this time, they do not want ventriculostomy placement despite risk of worsening neurologic function. They are driving in to discuss comfort measures.

- neurosurgery available for family discussion if requested
- appreciate MICU assistance in caring for patient
- discussed with attending Rickert

Electonically signed by:
Benjamin Paul Boudreaux, MD

Neurosurgery Attending

Pt is a 58 yo mans with an anoxic brain injury. There is no chance of a good functional outcome. There is no neurosurgical intervention that will improve his condition.

Electronically Signed by Kim Luann Rickert, MD at 07/29/11 0631

D/C Summaries signed by Charles Taylor Owens, MD at 08/16/11 2150

Author: Charles Taylor Owens, MD Service: Internal Medicine Author Type: PGY 3
Filed: 08/16/11 2150 Note Time: 08/16/11 2146
Related Notes: Cosigned by: Lance S. Terada, MD filed at 08/22/11 1253

58 year-old Caucasian male presented from prison after being witnessed to have a seizure while in common area. There are no details to the patient's clinical course leading up to his seizure and he has no known history of epilepsy. He reportedly had been in this prison for only 4 days and was recently at another jail facility. His jail is a non-air conditioned facility. His seizure occurred ~0300 hours and he was brought to Parkland by EMS. He was noted to be markedly febrile to 43° and with decreased responsiveness. In the ER he was initially hypertensive ~200/150, he had no gag, cough, or grimace and was completely unresponsive. The decision was made to intubate and he was given etomidate and succinylcholine. He was intubated without diffculty and a right femoral TL and right radial arterial line were both placed. His blood pressure decompensated and he was started on dopamine and levophed at high levels. Attempts were made to cool him with ice water NG lavage and packing his groin and axillae with ice packs. Pt had a poor clinical course with no meaningful neurologic response since arrival to the hospital. MRI was completed showing severe anoxic brain injury. Ultimately the family decided to make the pt DNR/DNI and comfort measures only and was terminally extubated.

Death Note:
This entry is clinical documentation by Charles Taylor Owens, MD regarding Patient
Larry Gene McCollum, 4493765. Mr. McCollum was examined by me and has no detectable
pulse, blood pressure, respirations, gag and corneal reflexes are absent and is deceased. The time of death was recorded at 11:35 pm on 7/28/2011
The time of this examination is 2356 on 7/28/2011.

All Notes (continued)

The Family has/have been notified.

Electronically Signed by Charles Taylor Owens, MD at 08/16/11 2150